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HEARINGS

BEFORE A

SUBCOMMITTEE OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE
UNITED STATES SENATE

EIGHTY-FIRST CONGRESS
FIRST SESSION

ON

S. 1106, S. 1456, S. 1581, and S. 1679

BILLS RELATIVE TO A NATIONAL
HEALTH PROGRAM

PART 2

JUNE 6, 7, 8, 20, 21, 22, 27, 28, AND 29, 1949

Printed for the use of the Committee on Labor and Public Welfare

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U.S. Congress. Senate. Committee on Labor and Public Welfare.

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UNITED STATES
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NATIONAL HEALTH PROGRAM OF 1949

MONDAY, JUNE 6, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:15 a. m. in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senator Murray.

Senator Murray. The hearing will come to order.

I should like the record to show that the absence of other members of the subcommittee does not indicate any lack of interest in the problem of financing medical education. In fact, each of my colleagues on this subcommittee is cosponsor of one or another bill to aid medical education, and I know they will study the transcript of these hearings with great care. Unfortunately, however, there are many other senatorial committees meeting today, and Senators Pepper, Humphrey, Neely, Taft, Smith, and Donnell have to attend those hearings.

The first witness this morning is the Surgeon General, Dr. Scheele. You may proceed, Doctor.

STATEMENT OF DR. LEONARD A. SCHEELE, SURGEON GENERAL, PUBLIC HEALTH SERVICE, ACCOMPANIED BY GEORGE ST. J. PERROTT, CHIEF, DIVISION OF PUBLIC HEALTH METHODS, PUBLIC HEALTH SERVICE; AND W. P. BEARD, ASSISTANT DIRECTOR OF VOCATIONAL REHABILITATION, UNITED STATES OFFICE OF EDUCATION, FEDERAL SECURITY AGENCY

Dr. Scheele. Mr. Chairman and members of the committee, health has become an issue of national prominence in the last several years. Both public and private agencies have put forward health programs, and the Congress has enacted a large number of health bills into law. I need only to mention the legislation creating institutes in cancer, heart, mental, and dental diseases, legislation authorizing programs in tuberculosis and venereal diseases, and grants to States for general health work and for hospital construction, to exemplify the leading role that the Congress has played in the promotion of the Nation's health. There is a considerable variety of further proposals pending before the committee at this time. A major obstacle to the fullest execution of most of these measures and proposals is the shortage of personnel. In many ways the lack of a sufficient number of qualified personnel to meet even minimum standards is the Nation's No. 1 health problem. It should have the highest priority. Naturally, therefore, we are gratified to see legislation proposed which would make a frontal attack on these shortages.

Throughout the rest of this week, while the committee is focusing its primary attention on the needs for personnel and on the problems of the educational institutions which are the training grounds, the committee will hear from organizations of educators, university presidents, and deans who are far more familiar with the details of administration of educational institutions than I am. Accordingly, I will not undertake this morning to go into details which will be discussed by the experts.

I would like simply to high light a few of the major issues, to summarize the major problems involved, and to sketch thereby the background against which the more specific testimony may be considered. The three principal bills before the committee are S. 1453, S. 1581, and S. 1679. I understand that S. 1453 has been superseded by S. 1679 and that these hearings are limited to the educational features of the other two bills; namely title VI of S. 1581 and title I of S. 1679. I have noted with much interest that still another bill, S. 1970, which was introduced only a few days ago and is not before the committee at this time, also recognizes these personnel shortages.

Superficially, S. 1581 and S. 1679 appear to differ substantially, but, as a matter of fact, their provisions actually represent a quite high degree of agreement. They both agree that this is a shortage of personnel. They both recognize that there are several professions which make up the health team and that there are problems in connection with the training of each. They both agree that existing information is inadequate and that a careful survey is needed to provide a basis for a continuing program. Both agree that, pending the availability of more adequate data, emergency aid is necessary now. Both also agree that there should be some stimulus to expansion, along with an emergency contribution to the operating expenses of the schools for maintaining present enrollment.

The two principal differences between title VI of S. 1581 and title I of S. 1679 appear to be differences of degree rather than of philosophy. One difference is with respect to the schools which would receive immediate financial assistance. S. 1581 makes provision for immediate assistance to only medical schools and defers aid to any other schools, while S. 1679 provides immediate assistance to the several types of schools. The terms of assistance under both bills would be subject to revision after the problem had been studied adequately.

The other major difference comes on the relation of grants for maintenance to those made for encouraging the expansion of medical-school enrollments. S. 1581 provides for $500 per student per year for existing enrollments and $750 per student per year for additional students, while S. 1679 provides $300 for present students and $1,700 for additional students.

Before proceeding to consider the more specific problems with which both bill deal, I should like to express our preference for S. 1679 because it attacks the problem more comprehensively and because it affords immediate assistance to several types of professional schools.

I have already said that the shortage of health personnel is acute.

Although there may be some disagreement on the precise magnitude of the shortage of physicians for the practice of medicine and for public-health work, there is no longer any real disagreement that a shortage does exist. Conservative estimates, based on present demands and on present rates of graduation, retirement, and death, indicate a shortage of at least 15,000 by 1960.

Beginning late last year the Federal Security Agency held a series of conferences with deans of medical and other training institutions for the health professions to get an appraisal of their views of what expansion was either possible or contemplated under present circumstances. It was obvious from the meetings that many medical schools can do little or nothing to expand enrollments now. In fact, I might add there was even some evidence that supporting the present basis was becoming more difficult in some of the schools, without reference to expansion.

Althought the total number of students in the schools of public health has increased constantly from 119 in 1930 up to 655 last year, they fall far short of the total number needed. These are the schools, you may recall, that provide postgraduate instruction for physicians, nurses, sanitary engineers, and other personnel needed for the key posts in Federal, State, and local public and voluntary health agencies. These schools must train 23,500 public-health workers by 1960, or 2,350 per year. This means that it would be necessary to multiply by three or four times the present annual enrollments.

The need for dentists is only slightly less acute. The most conservative current estimates place the need for dentists at at least 95,000 by 1960. There are about 75,000 active practicing dentists in the country today and, based on present rates of graduation and attrition, there will be a shortage of at least 5,000 by 1960.

There are 13 schools training dental hygienists, 11 of which are associated with and staffed in part by the dental schools. The present annual graduations of dental hygienists average only around 400, and without greater financial inducements to both schools and students, there is little prospect of approaching the country's need for these skilled workers.

The Nation requires a greater number of nurses than of any other one type of health personnel. While the supply of nurses is increasing the demand for nursing services has far outstripped it. Total enrollments have dropped form the war peak of nearly 130,000 to less than 90,000 each year despite vigorous recruitment efforts. Today the Nation has 280,500 professional nurses, which is 74,000 short of currently estimated needs. The total number needed by 1960 is conservatively estimated to be more than 400,000. This estimate, moreover, presupposes the supporting services of at least 200,000 practical nurses who require briefer and less-expensive training. Other than the shortage of total numbers of nurses the greatest need is for nurse teachers, which must be supplied if progress is to be made in increasing the total supply of nurses for hospitals, homes, and public-health agencies. Many hospital wards are now closed for lack of nurses, and many patients, particularly in mental hospitals, receive little or no nursing care. Some local health services are now without nurses, and the supply of public-health nurses must be substantially increased in order to meet the service standards contemplated in S. 522 now pending before this committee.

The goals for even minimum services to the people require the following annual average admissions for the next 10 years: 50,000 students for hospital schools of nursing, 8,000 students for university schools of nursing, 10,000 nurse students for advanced study, and 20,000 students for practical-nurse courses.

In 1948, only 43,000 students were admitted to university and hospital schools of nursing. During the war these schools admitted 65,000 students with the assistance of Federal aid. I think we all remember the well-known cadet-nurse program in wartime. In 1948, 4,700 full-time students were enrolled for advanced study. There were less than 3,000 students enrolled in practical-nurse courses.

Finally, we are faced with a shortage in still another category of health personnel, namely, sanitary engineers. These specially trained personnel are an essential part of the health team in every public-health jurisdiction—local health units, State health departments, and our Federal-health agency. Particularly if we are to achieve our goal of adequately staffed local health units throughout the country, we must step up our production of sanitary engineers.

Of the estimated total of 2,500 in the entire country, about 800 sanitary engineers were employed in State and local health departments at the close of 1947. On the conservative basis of 1 sanitary engineer to each 60,000 population, there should be about 2,300 sanitary engineers in State and local health departments alone. Most public-health agencies, like commercial waterworks, sewage-treatment and insect-abatement organizations, report acute shortages for established positions and urgent need for additional positions.

At present only 3 schools are accredited for training sanitary engineers, but 27 other schools offer options in sanitary engineering as part of the undergraduate curricula in civil engineering. About 125 graduate degrees in sanitary engineering and about an equal number of undergraduate diplomas were awarded in the academic year 1947–48.

Confronted as we are by the critical personnel situation in the health professions, let us consider remedial steps. Our primary immediate need is to increase the output of the several types of schools, but we are faced with the hard fact that nearly all these schools require financial assistance in order to maintain present enrollments. We can hardly expect expansion commensurate with needs if every additional student increases the deficits, even to the extent of eating into endowment capital for current operations. The real danger of retrogression unless some relief is offered was a definite conclusion coming out of the conferences with deans which I mentioned earlier. The representatives of the schools will give you the specific facts during these hearings, but it seems obvious that the schools must have some financial stability for what they are now doing in order to undertake significant expansions. An assured income, not subject to wide fluctuations from year to year, is necessary to attract and keep an adequate faculty.

No one has detailed data on the costs of the various types of education and on the precise financial condition of the schools, so I cannot give the committee exact figures. The gross total of the budgets of the medical schools, however, is something over $50,000,000 per year and the income from tuition and fees is about $13,000,000. Thus the medical schools must find from such other sources as State appropriations, endowment income, gifts and grants, and so forth, nearly $40,000,000 each year. I need not emphasize the fact that gifts and bequests are increasingly rare, that the yield from endowment has been declining, that much of the available endowment is restricted to special uses, that grants for research and special projects are made on a short-term basis and may or may not be renewed.

The other schools face a parallel though not identical situation. The graduate schools of public health face a particularly acute financial problem; the average costs are seven or eight times the average income from tuition and fees. Only two schools have any appreciable endowment at all. The high costs in the schools of public health are because the instruction is highly specialized, the classes are small and are conducted on an individual basis, and the faculty are engaged full time in teaching.

In the schools of dentistry the average cost per student per year approximates $2,000 (ranging from $1,050 to $2,350) and the average income from tuition and fees is about $500 (ranging from $200 to $850).

With respect to the schools of nursing, it is important to remember that there are three kinds of schools involved. There are (1) university schools with both graduate and undergraduate programs leading to degrees which prepare administrators, teachers, supervisors, public-health nurses, and nurses for special clinical fields; (2) hospital schools with programs leading to diplomas, which prepare nurses for general bedside nursing in hospitals and homes; ((3) practical-nurse courses in vocational schools which prepare practical nurses to care for certain types of patients who are not acutely ill and to assist in the care of others.

Like the medical and public-health schools, the university schools of nursing have higher costs than many other undergraduate and graduate college programs because students must have close individual supervision during their clinical practice. Only a relatively few colleges can afford this heavy expense.

Because the hospital nursing school is such an integral part of the hospital, it is not possible to discern on the basis of present information whether the deficits are those of the nursing school or of the hospital. It must also be recognized that student service pays for a large part of the cost of training in some of these schools.

Coming now to the problem of the best method of providing aid to the schools, we believe that it is sound to rely on an objective formula—as provided in both bills—which is as self-executing as possible, which leaves the minimum amount of discretion in the Federal administering agency, and which gives the maximum protection to academic freedom.

Both bills recognize that the necessary information is not now available on which to base a confident statement of how much is needed and what the precise basis ought to be. The authors of both bills place a wise reliance upon a careful study and both provide interim assistance upon a per capita basis. Both bills provide for a partial contribution to the cost of education on the basis of present enrollment and for removal of the economic barrier to expansion. With both principles we agree.

The two bills differ on the extent of the Federal contribution to the cost of educating present enrollees. S. 1679 provides for $300 per capita for each medical student and S. 1581 provides for $500. The latter figure may subsequently prove to be much nearer to what the schools will need on a continuing basis than $300, but we are confident that $300 per student will provide substantial help to the schools between now and the completion of the study. As I see it, the purpose here is to provide temporary emergency relief until the real needs can be determined. At least we are very sure that $300 per student per year will not prove excessive.

Similarly, the payments proposed in S. 1679 for other categories would be satisfactory as interim aid. They probably will later prove inadequate to put the schools on a sound financial basis, but the sums specified would be satisfactory in recognition of the necessity of selecting a figure somewhat arbitrarily in absence of all the facts.

Inasmuch as the schools are finding it difficult or even impossible to meet the costs of educating the current enrollment, significant expansion can be achieved only if the full cost of educating new students is met. The higher figures in S. 1679 for new students are based upon this principle. The average cost of educating a medical student is reliably estimated to be at least $2,200 per year, and the average income from tuition is $500. S. 1679 would make up the difference of $1,700 for each additional student in order that the medical school would not be hampered by increasing deficits as they expand. We feel this figure to be conservative; it is not a reward; nor will it afford a profit to the schools. It is simply a payment of cost. The figure may undergo some refinement after the study contemplated in the bill, but it is the best we have, based on published figures of the annual budgets of medical schools.

The provisions of S. 1581 also follow the pattern of a higher figure for additional students, but the $750 provided would not begin to meet the cost of additional enrollment. We feel that, of itself, the $250 differential for new students would have little effect in encouraging the desired expansion.

An important consideration in connection with expansion of enrollment is to insure the preservation of quality of training. Concern has been expressed lest the incentive of a large differential in favor of new students might stimulate unhealthy expansion—unreasonable inflation of enrollment in existing schools or the establishment of wildcat schools. We believe that a substantial differential is necessary to achieve the primary objective of increasing the supply of health personnel. As long as the differential is limited by the principle of net cost which I have described, I see no cause for alarm. We are confident, moreover, that the control of quality may safely remain in the professional accrediting bodies, where it now is, as recognized by both bills.

Further, in this regard, S. 1679 makes special provisions for the new schools which we anticipate will be established. It would be unsound to pay the full net cost for the entire student body of a new school. To do so would make the institution in effect a Government school. Section 372 (c) therefore provides that one-half the estimated average net cost per student be paid to new schools which are established during the interim period covered by the bill.

Parenthetically, I should point out that the provisions of S. 1679 for aiding hospital schools of nursing differ in principle from those for aid to all other types of institutions. S. 1679 recognizes that for training in these schools the primary problem is one of recruiting students. Instead of an outright financial grant to hospital schools of nursing therefore, the payments provide what is in fact an indirect scholarship. They are graduated moreover, in accordance with the recognized fact that in each succeeding year student nurses give increasing amounts of service and thus are a diminishing expense to the hospital.

In the series of conferences which the Federal Security Agency held with deans and directors of schools of medicine, dentistry, public health, nursing, and engineering, the question of bottlenecks to expansion was discussed. The character of these bottlenecks was necessarily varied; in some schools it was the lack of teaching faculty, in others it was the lack of classroom and laboratory space, in still others it was the lack of clinical facilities.

At least half of the medical schools, nearly all the schools of public health, and many of the schools of nursing will require new physical plants—both new space and replacement space—before any appreciable increase in enrollment can be expected. For example, the deans of medical schools indicated that in their present plant not more than 5 percent additional students could be accommodated. It has been recently estimated by the medical schools that nearly $200,000,000 is needed for modernization and expansion. The schools of public health have needs which total over $20,000,000. Although the schools of dentistry do not require additional plants to accommodate present students, any substantial expansion will involve capital costs. Practically all the major nursing schools will need added space for classroom and living quarters.

Most of the professional schools have definite plans for construction of new and improved physical facilites but it should be clearly understood that a substantial part of the contemplated construction is to replace antiquated and inefficient existing plants for the maintenance of adequate standards in instructing present students. Many of these schools have already raised varying percentages of the total capital needed for such construction but are unable to complete their fund goals.

With regard to administration of title I of S. 1679, the Public Health Service is in complete agreement with the provisions governing the National Council on Education for Health Professions proposed in section 102. As you know, we have had a long and satisfying experience with advisory councils composed of both professional and lay representatives outside the Government. They have provided essential assistance and safeguards in the development of our important special programs in the fields of mental health, heart disease, and cancer as well as in our general research program. They have made possible our record of assistance to and cooperation with nongovernmental institutions in the health field without interference with academic and scientific freedom.

The Public Health Service is in favor of Federal assistance to students who desire to take advantage of training for the health professions. This assistance is preferably given in the form of scholarships, although some consideration might be given to a combination of loans and scholarships.

It should be emphasized that the basis for financial assistance to students is quite different from the basis for assistance to the schools. Scholarships are primarily a device to equalize educational opportunity and to broaden the base for the selection of those who may receive advanced training. They will not necessarily contribute toward an expansion of enrollments. At the moment, for example, scholarships would do little or nothing to alleviate the shortage of physicians and dentists because the schools already have qualified applicants up to several times the present capacity. On the other hand, scholarships are needed at once to attract students to the public-health and nursing professions and to enable additional students to take advanced training. S. 1679 wisely does not undertake to specify the number of scholarships to be granted to each professional group. Congress can judge from year to year the factors affecting the need for scholarships and adjust appropriations accordingly.

The scholarship aid is granted on the condition that the recipient undertake to practice in certain shortage areas at the direction of the State agency. This provision raises a question of policy on which I would rather defer to the judgment of experienced educators.

Apart from the question of principle, there are some indications that repayment through service provisions may prove difficult to administer and even ineffective. The available experience of private foundations and even of a few States suggests that scholarship holders who elect to repay in service may not observe their obligation to serve and that it may be difficult to require those who default to repay in money. The observation of repayment provisions over a few years would demonstrate whether or not they are workable.

Finally, the provisions of part B of S. 1679 relating to the training of practical nurses meet with the general approval of the Federal Security Agency. There is already in existence a Federal-State organization in the field of vocational training which, as shown by the war training programs, is capable of prompt adaptation and expansion.

Mr. W. P. Beard, who is Assistant Director of the Vocational Educational Division in the United States Office of Education, is on my left, and he is here prepared to answer any questions in the area of practical-nurse training.

I should say also that time has not permitted clearance of our statement by the Bureau of the Budget. We understand that the Bureau of the Budget will submit its own recommendations with reference to the bills directly to the committee.

Senator MURRAY. It seems to me that the statement you have given us is a very clear and concise statement of the situation confronting us. But I would like to have any comments that your associate would care to make on the presentation you have given us.

Do you wish to make any comments on any of the matters he has discussed, Mr. Beard?

Mr. BEARD. Yes, Mr. Chairman; I would like to emphasize the fact that the vocational schools in training practical nurses at the present time are doing so under what is known as the George-Barden Act and using funds that are available for trade and industrial education.

The need is for an expansion of that program as well as to set the program up under a type of organization that is more adaptable than the George-Barden Act. In other words, the George-Barden Act works very well for trade and industrial and other vocational programs, but for this nurse-training program, practical-nurse-training program, we believe the present bill is much more adequate and that the need for practical nurses would be more adequately met under this bill than under existing legislation.

Senator MURRAY. Under present conditions are you finding it difficult to induce students to enter nurse training?

Mr. BEARD. No; we are not.

Senator MURRAY. You have plenty of applicants?

Mr. BEARD. We have applicants; yes.

Senator MURRAY. But you have not the facilities?

Mr. BEARD. That is right. This would provide facilities not provided under the George-Barden Act. We have a number of places which are ready to start if a program of this kind were made available.

Senator MURRAY. I see, and you approve of the program that we have presented here?

Mr. BEARD. Very decidedly.

Dr. SCHEELE. May I add a word to say that it is in the field of practical nursing we have more applicants than places we have for. Within the other fields of nursing we also have a shortage of applicants.

Senator MURRAY. I see.

Dr. SCHEELE. It is believed S. 1679 would go far toward inducing nurses to come in.

Senator MURRAY. In your statement you said that the scholarship aid is granted on the condition that the recipient undertake practice in certain shortage areas at the direction of the State agency. And you say there is some objection to that proposal. What are the objections to that?

Dr. SCHEELE. The objections are that some of our foundations have provided funds for training in which there was a similar provision, and there has been some difficulty actually getting the students to go there. In other words, when they finish school many decide they would much prefer to go to some other area, possibly an area where they might earn a higher income. Then one is faced with having to take punitive action to force a man against his will to go to an area where he is unwilling in his own mind to go, or to take legal action against him to make him repay the money.

We are not opposed to trying that. We think that something to help induce young men and women to go into the shortage areas is very useful and possibly having an alternate of service or repayment is useful to them too, because they are not bound then to go into the shortage area because they could repay it if we had that as an alternate.

On the other hand, we want to call attention to the fact it may in the long run have some problems in it, as we said: later on, after a few years of trial, we could find out what the problems were.

Senator MURRAY. In some areas of the country that are largely agricultural, that are not industrially developed, there are plenty of students that would like to find some opportunity to get started in life, and yet they have not the means to undertake an educaion of this kind. They have to leave their homes and go to other sections of the country in search of work.

Take, for instance, my State of Montana. We have practically no industrial development there, and the result is that our students leave the State and go to other sections of the country. I believe that many of those boys from the farm areas would be glad to take a medical education if they could afford it and had the opportunity to do so, and they would be happy to settle in their own State. Do you not think that is a reasonable deduction?

Dr. SCHEELE. We believe that is reasonable, and we do agree with the principle.

Senator MURRAY. The president of our State university on several occasions during the last 7 or 8 years pointed out that the boys and girls going through colleges and schools in Montana have no opportunity in the State and are compelled to leave. That is because of the fact that the State has no balanced economy and that the other sections of the country are increasing all the time.

I just saw an ad in the paper concerning Pennsylvania in which they are trying to secure more industrial development in the State of Pennsylvania, and they have a map to which they point and show that billions of dollars are being invested in new industries in that section of the country while other sections of the country are going without any development whatever. The result is that articles are appearing in magazines occasionally in which they show that certain sections of the country are being held in a state of undevelopment and are mere colonies for the industrial East.

So it seems to me that this scholarship idea for those sections of the country would be helpful.

Dr. SCHEELE. We certainly would agree, and we think it certainly is worthy of trial.

Also, we have some shortages in the national health services. I mean in the Military Establishment and also in the Public Health Servce and elsewhere where we find difficulty in filling them, and possibly some arrangement for some of these men to come to us would be helpful, too. We are like Montana in many ways in terms of our ability to attract people these days.

Senator MURRAY. Everybody wants to get into some of these big industries where they can become millionaires in a short time.

Does your other associate wish to make any comment?

Dr. SCHEELE. Mr. George Perrott, of our division of public health.

Mr. PERROTT. I have no comment to make.

Dr. SCHEELE. We think one very good thing in the bill with reference to these scholarship provisions is that an alternate is given to the individual to repay. In other words, he can make a selection, so he actually does not have a club over his head which forces him to do these things. He may do them; they are permissive. We think that is good because we have seen some little reaction on the part of the men who have been trained under the military-assistance programs during wartime. Psychologically one tends to resist having to do something he is told to do like serving in the military services for a given number of years.

Senator MURRAY. Yes.

Dr. SCHEELE. By allowing a release clause here, in a sense, the individual, if he wants to, can pay off his debt in cash rather than in service. But I think in Montana and in many other States we would find a large percentage actually coming back into the State and deciding to stay there. Of course, we should point out, too, many of the other programs in which this committee has played an active part in the past and with which it is concerned now—construction of hospitals and things of that sort—all complement the development of the program to make practice more attractive in the more rural and less densely settled areas.

Senator Murray. Yes.

I read an article in the paper just the other day, I believe, in which they pointed out that life is much more agreeable and satisfactory in the smaller communities than in the big industrial centers, and if we had these hospitals and clinics located there where they could practice the best quality of medicine, they would be more likely to find it desirable to settle in that kind of communities.

I thank you very much for your statement, Dr. Scheele. It has been very complete and to the point.

Dr. Scheele. Thank you.

Senator Murray. Our next witness is Dr. Joseph Hinsey. You may proceed.

STATEMENT OF JOSEPH C. HINSEY, CHAIRMAN, EXECUTIVE COUNCIL, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, ACCOMPANIED BY GEORGE PACKER BERRY, M. D., ASSOCIATE DEAN, UNIVERSITY OF ROCHESTER MEDICAL SCHOOL; W. A. BLOEDORN, DEAN, GEORGE WASHINGTON MEDICAL SCHOOL, WASHINGTON, D. C.; CARLYLE F. JACOBSEN, EXECUTIVE DEAN, DIVISION OF HEALTH SCIENCES, STATE UNIVERSITY OF IOWA; WARD DARLEY, M. D., DIRECTOR, UNIVERSITY OF COLORADO MEDICAL CENTER, EXECUTIVE DEAN IN CHARGE OF HEALTH, SCIENCES, AND SERVICES, UNIVERSITY OF COLORADO; AND DEAN F. SMILEY, M. D., SECRETARY, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, CHICAGO, ILL.

Mr. Hinsey. Mr. Chairman, I am Joseph C. Hinsey, the chairman of the executive council of the Association of Americal Medical Colleges, and I am accompanied here by some of the members of our council, and I would like to introduce them.

Senator Murray. Very well.

Mr. Hinsey. Dr. Dean F. Smiley is the secretary of our association.

Dr. Ward Darley is the director of the health sciences and services at the University of Colorado.

Dr. Walter Bloedorn is dean of George Washington University Medical College.

Dr. George Berry is associate dean at the University of Rochester, and dean-elect at Harvard University.

Carlyle F. Jacobson is executive dean of health sciences at the University of Iowa.

Senator Murray. Thank you. They may be seated here at the table. This is a very impressive panel.

Mr. Hinsey. Senator Murray, this is a statement I have prepared but it is a statement which has been unanimously endorsed by the executive council of the Association of American Medical Colleges.

At present there are 71 approved 4-year medical colleges and 7 approved schools of basic medical sciences in the United States; 43

of the schools are privately supported and 35 are tax-supported; some 31 are State, 3 are municipal, and 1 is Federal; 68 schools are integral departments of universities, 10 are independent institutions without university affiliations.

In the year 1947–48, there were 22,248 students in attendance in all 4 classes and 5,543 physicians were graduated. During the current academic year, approximately 5,150 students will graduate. This present fourth-year class is small because it was selected in the last year of the war when there was no provision for the deferment of premedical students by the Selective Service System. This decrease in number of graduates is temporary and the total number of graduates will increase next year.

I may say that the estimate for enrollment in the first-year class, as nearly as we can determine at the present time, probably will exceed 7,000. And the number of enrollment, say, for last year was about 6,200. And without any impetus of any sort of Federal legislation, the medical schools in this country are increasing their enrollment. I think that is evidence of their desire to do the right thing for national health.

The enrollment of 22,739 students during 1947–48 is 2,212 greater than the average during the 5-year period preceding the war despite the fact that the then third-year class was small.

Senator MURRAY. Why was there not an increase in students during that period?

Mr. HINSEY. We had one class that was small because of the fact that the selective service did not defer, and that class was small not only in medicine but in other fields. But it was particularly true in medicine. That is the reason. That was then the third-year class, our present fourth-year class, that was small at the time of entrance back at the end of the war.

Senator MURRAY. I see, thank you.

Mr. HINSEY. During the present academic year, these 78 schools are operating on budgets which total about $51,000,000, of which $12,800,000 is derived from student fees. That is approximately 25 percent.

Twenty million and seven hundred thousand dollars is derived from endowment income, gifts, and general university funds for deficit financing. I think that is an important point that universities have found it necessary to take from their general funds to make up deficits incurred in the medical schools.

And $17,500,000 from tax sources. The average tuition is $513, the maximum being $830 and the minimum under $100 in one of the State institutions. Although it is a difficult matter to state definitely, it is estimated that the average cost per student is about $2,200 with a range from $735 to over $5,000. Sixteen schools spend less than $1,500 per student and 39 more than $2,000.

Today medical education is the most expensive of all forms of education. Many factors combine to make this so. The primary factor is that every prospective physician must undergo an intensive period of individual study in classrooms, laboratories and hospitals before he can be allowed to assume responsibility for the life and health of his fellowmen. The training of doctors involves a large number of highly skilled teachers in proportion to the number of students—

teachers who must be paid salaries which are not too far out of line with those they could command in private practice or in business or industry.

And I may say that is one of our great problems, the matter of attracting new people into medicine and of holding people that are already there in terms of the salary scale.

It requires extensive laboratory facilities and specialized equipment which are costly to secure and to maintain. It involves the use of vast clinical facilities in hospitals and clinics where patients of every type may be cared for and studied. These are some of the reasons that the medical schools today present a great financial problem. The costs per instruction would be greater if it were not for the donations of time by many physicians who devote only a part of their time to teaching and if it were not for the costs that are carried by many of our great teaching hospitals.

The Association of American Medical Colleges is an educational association made up of the approved medical colleges of the United States and Canada, including the College of Medicine of the University of the Philippines. It will hold its sixtieth annual meeting this coming fall. Its central office is at 5 South Wabash Avenue, Chicago, Ill., and its full-time secretary is Dr. Dean F. Smiley. It is devoted to problems of medical education and publishes the only journal devoted solely to this field.

Senate bill 1453 was sent to the deans of all 78 approved medical colleges in the United States on April 12, 1949. They were requested to study this bill and discuss with their appropriate university authorities and to send in their reactions to it. The provisions for aid to medical education in Senate bill 1453 are quite similar to those in Senate bill 1679. Senate bill 1581 was also sent to the medical colleges later, but the testimony to be offered reflects the opinions received on S. 1453 from 45 of the schools—and I have received responses from three more which are not included—which were about equally divided between private-supported and tax-supported institutions, as a matter of fact, 22 private and 23 tax-supported institutions.

As I have said, I received three more replies. Although I have no definite information from our schools, it would be my impression that they would be in the large majority in favor that medical education be provided aid under a separate bill like S. 1453 than in an omnibus bill like S. 1679. Some deans think that it would be preferable to provide for medical, dental, and graduate public-health education in one bill and for nursing and dental hygiene in another.

Those are just some of the expressions that were given.

With respect to additional students, these 45 schools estimate that 43 students could be added to their entering classes with the aid of new construction provided in the bill. Twenty-three of these forty-five schools estimate that their share of new construction would be $49,900,000, practically $50,000,000, as the school share of new construction. And that is 45 schools.

Of these 23 schools, 10 privately supported ones estimate their share to be $12,525,000, and there was doubt expressed over ability to raise construction money in some instances. They said, "This is the need. We will try to raise it, but we do not know whether we can or not."

In some instances the money was in the treasury of the institutions.

About $37,375,000 represents the estimates from tax-supported institutions. The suggestion was made that it would be better to provide for construction on a basis of matching of two parts from Federal funds to one from the institution. That is the 1 to 1 ratio is found to be rather difficult in some of the institutions.

The comments from 28 institutions criticized the $300 per student maintenance fee. This amount would help but in school after school it would provide only a fraction of the present need.

And in the comments they spoke about how it would be possible for them to replace certain faculty positions that have been deleted, and to increase salaries in some ranges where it needed to be, and in some the money would be used for facilities in terms of laboratory apparatus and teaching facilities.

In addition to undergraduate medical students, all medical schools carry a very considerable number of what may be termed "graduate students, which include interns, assistant residents, residents, and fellows." Sometimes these people are registered as graduate students in the university.

These are the responsibility of medical schools in teaching hospitals and occupy a great deal of the time of the clinical departments. Some of these are found in the basic science departments. It was suggested that the medical schools should press for the recognition of these individuals as members of their student bodies since they are students completing their medical education.

And I may say that this group finds there are many problems on which they need aid in continuing in this graduate education, and that need is expressing itself more now as the GI bill is running out.

The difference between the $300 per student now enrolled and the $1,700 incentive for new students was criticized by 32 schools as being too great. Fear was expressed that incentive of $1,700 would cause schools to expand beyond their facilities and thus lower their standards of medical education.

Senator MURRAY. I might say, of course, appropriations would be made periodically and that could be handled whenever the matter would be considered by the Appropriations Committee. They could control it or regulate it or modify it in any respect.

Mr. HINSEY. Senator Murray, the problem is this: If we built up our budget with this in mind and make appointments with tenure, then if we would have some decrease, as happens in appropriation, or happened to be cut off the schools would find themselves with an elevated budget and what they would really be doing would be increasing the deficit.

Senator MURRAY. That is right.

Mr. HINSEY. That is the concern that schools have. And I think it was pointed out in our committee meetings we had with the agency, and it is a concern that is fairly general among the medical schools.

The same concern now applies to the $300 per student now enrolled. Without assurance of continued support, it would be equivalent to building up greater deficits and experienced administrators will not do this. I appreciate the difficulty of assurance in Federal appropriations.

If we were to include the student body at the University of Washington which will have a 4-year program in operation next year, and that at the Chicago Medical School which was approved last fall, the total student enrollment for next year would approximate 23,000. I think I have been very conservative there because with the increase in first-year class, I believe it will be greater. But that is a conservative estimate.

At the rate of $300 per student this would require $6,900,000.

From the 45 schools included in this report, the rate of addition of new students was slightly over 10 per school per year. If this rate were maintained for all 78 schools, the cost of $1,700 per each additional student would be about $1,400,000 per year, and over 4 years this would approximate $5,500,000 per year, because we have an addition to the number.

However, it should be remembered that the increase in some institutions was contingent upon funds for construction and new buildings which would take time. The University of California at Los Angeles has started the organization of a new medical school, but students have not been accepted there as yet.

I think that is very interesting in terms of starting a new school. The planning and starting of that school has been going on over some year or two and students have not been accepted. And they may not be accepted for another year or two, maybe 1950. I think it is an example of what is involved in starting a new institution. It takes time.

Senator MURRAY. Where a university already has a premedical course, would they have much difficulty in expanding that?

Mr. HINSEY. They have a premedical course at the University of California at Los Angeles, Senator Murray, and have had a very strong one over a period of years. But the problem is the assembling of a staff, provision of buildings, and getting hospital facilities. It is a time-consuming process. I think that is a good illustration of what is involved.

Senator MURRAY. Yes.

Mr. HINSEY. In regard to the scholarship program of S. 1453, there was prevalent concern about the necessity of establishing need on the part of the candidates. In S. 1679 there is a statement of why it is necessary to have the scholarships. But the deans did express concern that this be done on the basis of need.

There was quite general apprehension about political pressures upon admissions committees and officers if the scholarships are to be awarded before admission to medical schools. Many schools believe that the scholarship awards should be made to those already admitted to medical schools. Many schools are opposed to the requirement of indentured service upon completion of training. However, S. 1679 does provide a release clause on page 28, lines 16 through 23.

Several schools recommended that a loan program would be better with a provision made for allowance for retirement of a loan at an annual rate for (*a*) service in governmental agencies, whether it be Federal, State, or at the local level; (*b*) teaching and research. I think that is an item that is not included in the bill that would be an important provision and encourage people to go into teaching and research whether it be in private or governmental agencies, and thirdly for service in rural areas with low physician populations.

With the GI bill benefits gradually passing out of the picture there will be need for student aid of some type, but schools must be free to select students on a fair basis as outlined in S. 1670, page 12, lines 1–3. Paragraph (b), page 23, of S. 1453, and paragraph (b), page 31, of S. 1670 are designed to protect this freedom.

Senator MURRAY. Doctor, I would like to ask you what could be accomplished in the way of increasing the number of doctors that could be graduated if the schools were continued on a year-round basis?

Mr. HINSEY. That has been done in certain places. The University of Tennessee admits students every quarter. The University of Chicago has continued a four-quarter program. In some instances in some institutions the problem would come in the inadequacy of the clinical facilities for teaching and for taking care of the piling up that would happen in a continuous year-round program.

It was our experience, Senator Murray, during the war—to be sure we were working with reduced staffs—but I believe it was rather the general experience, and I would like to have comments from some of the other people here. Dr. Berry, you have had quite a bit of experience in studying the impact of that.

Dr. BERRY. Senator Murray, my comments would be this: A school not only trains physicians, it produces new medical knowledge. It teaches people at all levels. The most effective teacher is one who has at least half his time for production of new knowledge, half his time for other teaching and patient-care program.

To teach the year around puts such a load on the faculty that to maintain that standard of activity requires almost twice as large a teaching staff to do it well. At the present time our problem is inadequate teaching staffs as it is, and those that I have discussed this with extensively believe we would lose a good deal more to try to squeeze those 3 months in at the expense of research than we would gain.

Senator MURRAY. You could not do it with the existing staff?

Dr. BERRY. We would not do it.

If I may add one other comment, I would like to put this fact on record. It has been emphasized by many people that the primary problem this committee is considering is the increase in medical personnel. I would like to state the primary problem is first the maintenance of the concerns that are going now. It seems to me like whipping up a half-starved horse. If you want him to run faster or carry a heavier load, the first thing to do is to feed him well and get him healthy, and I believe our primary job is to get the enterprise of medical education, which is at the core of this whole business.

You cannot have more service, you cannot implement and fill more hospitals, you cannot do other things until you have the doctors to do it with, and that is the primary purpose.

I mention that only because it is an integral part of teaching 12 months a year. I do not believe in whipping up a half-starved horse to make him run faster.

Senator MURRAY. When you made that remark it reminded me of a situation in the dog-racing business where you can fix the races by feeding the dog a little too much so that he will not run so well. Nevertheless I think your comment is well made, and it is our intention after we get through with these hearings to have you men representing the medical schools sit down with us and try to work out a bill. There is no controversy among us up here in regard to this problem. It is simply a question of trying to get the proper solution, to get the proper kind of legislation, and we want your assistance. We will ask you to come and join with us and sit down and help us in working out the final bill.

I think that your suggestion with reference to having it as a separate bill is all right. I can see no objection to it. Of course, it would be a fine thing for some of us if we could keep that in there and at the same time have our socialized medical care program attached to it so we could pass them both together.

Mr. HINSEY. Do you mind, Senator, if I stay by the educational picture here this morning?

Senator MURRAY. I wanted to say in your discussions here today we are just talking about title No. VI in 1679, and your approval of this does not bind you in any way to the other provisions of S. 1679.

Mr. HINSEY. Thank you very much, sir. Shall I continue, Senator?

Senator MURRAY. You may go ahead.

Mr. HINSEY. Of the 45 schools from whom comments have been received, 14 favor the National Council on Education for Health Professions. Among the remaining 31, there were expressions that this would indirectly place too much power in the hands of the Surgeon General of the Public Health Service.

And may I say parenthetically there is no lack of trust in our present Surgeon General; it is just a matter of the general principle involved.

Among the recommendations that were made are the following: That the functions of this council should be more clearly delineated; that it should have power to recommend and approve projects and programs; that consideration might be given to ex-officio representatives from some of the national organizations in the various fields of health education.

Attention should be paid to determine how many additional physicians are needed. In addition to the new 4-year medical schools already mentioned, that is, the University of Washington at Seattle, the Chicago Medical School, and the University of California at Los Angeles, a new 4-year school is being organized in North Carolina and the State of New York is deciding where to locate two State medical schools. North Dakota, Mississippi, West Virginia, Florida, Missouri, New Jersey, and Connecticut are considering the possibility of 4-year schools. If legislation like S. 1453 or S. 1679 is passed, half the costs of construction would be shared by the Federal Government and each student might mean an outlay of $850 per year. That is on page 15, line 6 through 20, of S. 1679.

State legislatures have exerted pressures to increase numbers of admissions to their medical students. Is there to be a ceiling or are we to pursue unlimited expansion? Problems created by shortages in teaching personnel already existing in some fields can be greatly exaggerated in an uncontrolled expansion.

And I think I can support that from certain fields. For example, a study has been made by the American Association of Anatomists that shows a number of unfilled positions at present and the age distribution at the professorial level. There is no question but there is a real shortage there. They are trying to do something about it, but it takes time. In many ways it is the result of several factors:

During the wartime we did not have a chance to train young men, and at the present time in an inflationary cycle we have had problems of finance that we have not been able to bring in as many as we think we should.

Senate bill 1453 and title I, part A, of S. 1679 places most of its emphasis upon expansion of numbers of students in medicine and too little upon the maintenance of standards and quality in our present operations. The latter constitutes the most urgent need in the health-training picture. Exact data supporting this need are not available now, but are being obtained.

The plight of our voluntary teaching hospitals is one that is affecting the whole program of medical education. The inflationary cycle has caused increases to costs to the point where many of them are running large deficits which are being met out of capital funds. This cannot go on and is already exerting a deteriorating effect on undergraduate and graduate medical education.

I realize that is not part of this bill, but it is important to point it out because it is having its effect in many of our medical schools.

A survey on medical education is now under way supported from private sources. This will provide much useful information for long-term planning. The study now being conducted by National Advisory Health Council is designed to study the impact of the grant program of the United States Public Health Service on medical education, but it is bringing together data which pertain to the present financial structure of medical schools.

The Association of American Medical Colleges fully appreciates the plight of many of its member colleges and the effort they are making to maintain and improve the quality of their work. We do not oppose expansion of numbers and have not in the past, but we feel it our obligation to emphasize that the goal should be determined and that the final product should be well trained in the best interests of the improvement of our national health.

It has been difficult to summarize all of the reactions received. The following statements may sum up our general position:

1. There is a definite need now for Federal aid to medical education provided the educational and administrative policies can continue to rest in the hands of the medical colleges without political interference.

2. Such aid should not interfere with private and State aid.

I think it is important to emphasize that because if aid of this kind is available, and if that amount is a decrease from the State appropriation, in the long run no good has been done. So we have to be sure that there is no interference. That same thing holds for private support of the universities, that the universities do not decrease their support in a budgetary way of the medical school in any amount due to the aid that might be forthcoming.

I think there are some exceptions where deficit financing has been done. I think it would be all right for universities to take care of that, but it is a point of real importance in any legislation that is written.

3. Aid to students should have a need qualification. If there is any indentured service, it must have an escape clause. Scholarships should be awarded to those already admitted to medical schools. Many educators prefer aid in the form of loans.

I would like to add a clause to our statement here. Others prefer gifts instead of loans in view of the long training period involved. A young man may go through a period of 7 or 8 years, and if he accumulates a large loan he is carrying a very heavy load when he leaves. But I thought it was important to emphasize this loan phase because it is the impression of many of our medical college deans that would be a good, safe way of handling it.

4. Attention must be given to the maintenance of standards in the present medical school operations. Incentives for new students must not be so attractive as to cause expansion beyond facilities and at too rapid a rate.

Dr. Alan Gregg, the director of medical sciences of the Rockefeller Foundation, has been associated with this foundation for the past 27 years and has closely followed and been identified with the development of medical education. Recently he said:

> I wonder if Americans understand how alarming is the future of medical education in this country. Unless our medical schools receive substantially larger sums for their essential expenses, we shall not in the future have the care which modern medicine could provide. For it is only through the hands of men and women trained by our medical schools that society provides itself with medical care.

Senator MURRAY. That is a very excellent statement, Doctor.

Now I would like to hear from any members of your panel.

Mr. HINSEY. I think that would be fine, Senator Murray. Dr. Jacobsen and Dr. Darley both have problems of not only medical schools but they happen to be directors of health sciences in their institutions, and they are two of our great State universities. I am sure they could add to what I have said and reflect problems they have which would be of benefit to you and your committee.

Senator MURRAY. Very well, I will hear from you, Dr. Darley.

Dr. DARLEY. Senator Murray, I do not have a great deal to add to Dr. Hinsey's very complete statement. I am delighted to hear there is a chance that those of us concerned with these problems will have an opportunity to work with those of you who will be writing the legislation aimed at solving some of these problems.

I also would like to emphasize my feeling regarding the importance of limiting the consideration of any bill to the problems of education for health service and keeping it on a nonpartisan basis. I think that is highly important.

The State university problems are not unlike those of the private institutions. If there is any difference it is usually to be found in the unpredictability of the biennial State legislative appropriations. And as a result the sense of security and sense of stability in our educational programs is not what it ought to be. And if we could have more sense of security the faculty could operate more effectively, I am sure.

There are many problems that are intimately related to the situation under discussion that do need very thorough discussion with those of you who will be giving further consideration to legislation.

I think one thing that needs to be emphasized very greatly is the importance of graduate medical education. That is the educational activity beyond the usual 4 years in the medical school and 1 year's internship. The time has come when almost all graduates in medicine must look to another 3 to 5 years of training. And I think the needs of that group need to be looked into very much.

These individuals are older. They have gone past the time in life when they should begin to have their families and they do need security.

The idea of guaranteeing bank loans to this group has been suggested as one solution. Right now this type of education has been stabilized by the GI bill of rights and, of course, that will not last must longer.

Problems concerning scholarships and admissions of students, getting doctors into areas where they are badly needed all deserve considerable discussion, and I am sure that ways and means of solving these problems can be worked out if the opportunity is afforded for such consideration.

Thank you.

Senator MURRAY. You have had some experience in this problem of getting doctors into communities where they are needed?

Dr. DARLEY. Yes, we have, Senator. I think it can be done. I think the key of the situation is to provide facilities, hospital facilities, and diagnostic facilities in those areas.

Senator MURRAY. We seem to find considerable difficulty in getting students from Montana into medical schools. I hope that as a result of this legislation we will be able to accomplish something along that line.

Dr. DARLEY. In Colorado we are, as you may know, giving serious consideration to putting our school on a regionalized basis with regional support, and we are very much interested in working with the State of Montana on that problem.

We find that one of the important things in getting students to go into rural areas is to provide ample opportunities for adequate training for general practice. I think there are other approaches, in other words, other than the scholarship idea admitted, that may play an important part in meeting the problem.

Senator MURRAY. Thank you, Doctor. Your comment on the idea of having this as separate legislation was noted. Our reason for including it in an omnibus bill was to show its interrelation to the other problems, and when you read it in connection with the entire program you can see that it was a justifiable procedure.

Nevertheless, we want to get this legislation enacted promptly, and I see no objection to having it separated from the omnibus bill and passed as an individual measure.

When we get through the hearings, we intend to invite you to sit down and help us to work that out.

Dr. DARLEY. I can appreciate your viewpoint. On the other hand, we have this problem of the shortage of personnel regardless of what other measures seem worthy of consideration, and I believe if this consideration can be kept by itself, from our standpoint at least, we see where Federal aid can be worked out in much less time than if an effort is made to solve everything at once.

Senator MURRAY. Dr. Smiley, do you wish to comment?

Dr. SMILEY. I would just like to call attention to the earnest way in which the present medical schools are trying to meet the need. They have been inundated with that large group of GI bill of rights students who get their arts college education, and they cannot just add a lecture in a lecture hall and expand that way. They have to have laboratories and demonstration facilities and so on.

I was in a school recently where they have actually taken out the demonstration bench and put student benches instead, and put the demonstration material on carts to move through the aisles. That is how hard they are trying to meet the need.

Senator MURRAY. Thank you, Doctor.

Do you wish to comment, Dr. Jacobsen?

Dr. JACOBSEN. Senator Murray, I am scheduled to make a statement on behalf of the National Association of State Universities tomorrow, so I will reserve the major portion of my remarks until that time and restrict my remarks now to the endorsement of what Dr. Hinsey has said. And I wish to emphasize some of the points of view of the State universities it is important that we provide ways of maintaining the present support from our tax sources. I think if we merely substitute Federal aid for State taxes, we will have defeated our purpose.

Senator MURRAY. Thank you, Doctor.

Do you wish to comment?

Mr. BLOEDORN. I would just like to endorse Dr. Hinsey's comment. I think he has covered the subject very adequately.

The need for financial aid to medical education, I believe, is quite apparent. There seems to be unanimity of opinion on that subject.

I would also endorse the viewpoint that separate legislation would be in order and perhaps more quickly aid us than an omnibus bill.

Your comment on the dog race, I think, is quite in order. I merely add that the medical schools would require a considerable increase in rations before they would arrive at the overfeeding point.

Senator MURRAY. Dr. Berry, do you wish to comment?

Dr. BERRY. Senator Murray, there is one other thing I would like to say, and may I introduce it in this way: That deans are people who do not know enough to be professors but know too darn much to be college presidents.

I say this in the light of having worked not only with the president of my university, but with the group that is known as the Association of American Universities. And I can realize the headaches that college presidents have when they have medical schools in their midst. Nothing is bankrupting them more rapidly.

I say this only to add that the Association of American Universities has had a committee for a year or two studying this problem of which Chancellor Wriston of Brown University, of Providence, is chairman. Mr. Conant has served on that committee from Harvard, and Dr. Hutchins from Chicago, and a number of other distinguished men. And we had Chancellor Gustavson of Nebraska who is going to come before your committee.

I just wanted to say this: As Mr. Rodgers of the committee staff has evidence of, I have been appointed by the committee to speak for them as well as the medical schools and tell you they have studied carefully the document Dr. Hinsey has read and endorsed in full.

Senator MURRAY. Thank you, gentlemen. It has been a very satisfactory presentation this morning.

I will ask you to get in contact with the members of my staff so that they may arrange with you for a time to go into this subject.

Mr. HINSEY. May I say we are very appreciative for having this opportunity to appear here today.

Senator MURRAY. Our next witness is Dr. Leonard Carmichael, president of Tufts College.

STATEMENT OF LEONARD CARMICHAEL, PRESIDENT, TUFTS COLLEGE, MEDFORD, MASS.

Mr. CARMICHAEL. My name is Leonard Carmichael. I am president of Tufts College at Medford, Mass., and am also a member of the committee on relationships of higher education to the Federal Government of the American Council on Education.

The council consists of 68 constituent members, 57 associate members, and 929 institutional members composed of higher educational institutions and school systems, both public and private.

The members of the committee on relationships are as follows:

Arthur S. Adams, president, University of New Hampshire, Durham, N. H.

Leonard Carmichael, president, Tufts College, Medford, Mass.

Carter Davidson, president, Union College, Schenectady, N. Y.

Virgil M. Hancher, president, State University of Iowa, Iowa City, Iowa.

Rev. Edward V. Stanford, rector, Augustinian College, Washington, D. C.

Raymond Walter, president, University of Cincinnati, Cincinnati, Ohio, Chairman.

Roscoe L. West, president, State Teachers College, Trenton, N. J.

Goodrich C. White, president, Emory University, Ga.

George F. Zook, ex officio, president, American Council on Education.

Francis J. Brown, staff associate, American Council on Education, secretary.

At the meeting of the committee on May 16, it unanimously endorsed in principle those sections of S. 1679 which provide Federal assistance to both privately and publicly controlled institutions providing professional training in the fields of medicine, dentistry, nursing, public health, and sanitary engineering, and other bills would be supported so far as the provisions are approximately similar.

The committee believed that all three types of aid included in the bill, S. 1679, are important: for cost of operation; for construction and other costs to provide physical facilities; and for scholarship aid to students. But the committee was strongly of the opinion that the most imperative present need is assistance in bearing the operational costs of the institution providing training in these fields.

I need not take your time to emphasize the importance of these fields in the national interest. Their importance is greater today than ever before because of the increased birth rate; it is estimated there are now some 8,000,000 more children under 9 years of age than there would have been if the birth rate of the 1930's had continued. It is important also because of the rapid advances in all of these fields which entail a higher level of training and increased specialization. But what I want especially to emphasize is that the vital importance of all of these fields make financial assistance to them by the Federal Government seem to be essential to the advance of the public welfare.

I may say parenthetically I personally have come to that decision after a great deal of consideration because I am not one who believes that the Federal Government should help in every activity of the States or private support. But this seems to me to be a great exception to other problems we are facing.

But it may be asked why should the Federal Government begin now to expand the public welfare clause to provide financial assistance to this special group of professional institutions?

At least three answers to this question occur to me: One is that the need for manpower in these fields is very great today. I have already referred to the increase in population but there are other factors which bear upon this question. Our armed forces must secure the services of many additional physicians and dentists. These professional men are absolutely essential to the welfare of our armed forces in this period of great international uncertainty. The civilian population has now only one doctor for approximately each 700 persons, a large proportion of whom are children and elderly persons for whom medical and other health care is imperative. If the needs of the national defense are to be met, the training facilities for these fields must be expanded beyond the prewar level. Such expansion is costly both in initial outlay and in operating costs.

The second reason why financial assistance is needed now is the rapid increase in the cost of operating institutions to train professional men and women. In the last 10 years the equipment required to train students in these fields has vastly increased in cost. Many instruments of an old-fashioned simple type are now supplanted by electronic and other devices which often cost not ten but thousands of dollars. Today it involves machines such as the electrocardiograph costing more than $1,000 and many of these must be duplicated for individual students.

Even the simple laboratory equipment now costs two or three times what it did in 1940. But physical equipment is not the only increase in the cost of operation.

Faculty salaries in these fields have also had to be increased. Especially in clinical teaching the salaries paid to full-time professors are now up to twice as high as the compensation paid regular faculty members.

Specialization and research tend constantly to reduce the faculty-student ratio—and they should—and make it necessary also to increase the faculty even with the same number of students. The actual cost for operational expenses in medical schools average approximately 2,500 students per year. The result of these increasing costs now make the professional school in these health fields draw heavily upon the total university budget frequently at the expense of other schools of the university.

The third reason is that other sources of income to these fields are decreasing. I am informed that 85 percent of all money raised by taxes of all kinds—local, State, and National—are now levied by the Federal Government. This means two things: First, that revenues from local and State taxes are not sufficient to meet the expanding needs and, second, that less money is now available which might otherwise be given to educational institutions from private sources. The rate of income on endowment funds have decreased in recent years. That is taking for example a 10-year period.

Student fees have been raised but there is a limit above which they cannot go.

Even now medical and dental education is restricted to individuals who can finance training which costs, including room and board, up to $3,000 a year.

Institutions of higher education and especially those operating professional schools face a dilemma. The need for trained personnel in the health fields is rapidly increasing. The cost per student is now almost twice what it was in 1940. Every possible present source of income is either constant or actually declining and the only resource is to turn to the Federal Government.

Thus far, I have talked only in general terms, I should like now to use my own and several neighboring institutions as typical of the dire problems which we now face in maintaining adequate training for the health fields and which are even more serious in the light of needed expansion to meet increasing needs.

Except for a few thousand dollars in Vermont no State appropriations are made for medical or dental education in New England. The nonpublicly supported schools in this area must therefore carry the burden of providing physicians and dentists and other medical personnel for this whole group of States.

To take Tufts Medical School, of which I am president, as an example in 1937–38 the total budget of the medical school was approximately $272,000.

Now some of my wealthy friends behind me here will say that is a budget of a single department, not of a school, sir, but it was the budget of our school because much of the teaching was done in cooperating with hospitals. But it was a very economically administered school.

Nevertheless, I may also add that more doctors are in practice in each of the New England States who have graduated from Tufts College than any other. In other words, for better or for worse the business of training a great many of the doctors for this whole area rests on us.

Dr. Berry will soon be head of Harvard, which is a world school, not only for New England and Massachusetts but for the world. Ours is primarily a regional problem. In fact we have no students outside of the area.

Last year the cost was over $646,000. The number of students remains constant; of this total change of income tuition provided an increase of only about $48,000. The Tuft College Dental School shows a similar change.

We are operating under a large deficit and this cannot continue indefinitely. New England people and especially our alumni have made generous contributions to our Schools of Medicine and Dentistry but private benefactions do not seem able to carry the burden.

In the light of these facts, the committee on relationships and I personally strongly urge this committee to appove financial aid to institutions training young people for the health fields specified in this bill. Financial assistance for both operation and construction is imperative. Some scholarship program for students may be advisable but the real need is that of the institution.

But the basic need at the moment is for assistance to the institutions if they are to continue to do an effective piece of work in this difficult and all-important field.

Thank you very much.

Senator MURRAY. Is it difficult to single out in your budget the costs of medical education? It is something that has to be taken into consideration with reference to the maintenance of the entire school, is that true?

Mr. CARMICHAEL. Mr. Chairman, it is not difficult to single out the cost of medical education as distinct from the other departments of the institution, but it is difficult to compare the budget of various medical schools in which teaching hospitals are under the direct administration of the medical school and schools in which the teaching hospitals are under boards of trustees and are supported either in part by public or by private funds.

I might add, for example, that one of the main teaching bases of our medical school is the great Boston City Hospital. Now the Boston City Hospital is supported in large measure by the city of Boston.

We also have other university teaching hospitals.

I am the chairman of the board of trustees of what is called the New England Center Hospital, which has a large budget, but no cent of that money of that budget comes from the medical school although that hospital pays the salary of some of the clinical teachers.

I mention this fact to suggest that the study proposed in all of these bills is very important if an appropriate formula is to be arrived at by means of giving what I think is necessary assistance to the schools.

Senator MURRAY. Thank you, Doctor. You will be able to render us assistance when these hearings are concluded.

Mr. CARMICHAEL. Thank you very much, Mr. Chairman.

I would like to say that I represent one of the medical schools that may almost be forgotten because I cannot pretend that our is a well-to-do medical school. Most of the people that will come before you come from these very expensive great research medical schools, and I do hope that as you think about the problems you will not forget that there is a middle group of medical schools trying to do a good job, but these medical schools have possibly the greatest financial problems of all.

Senator MURRAY. Thank you, Doctor. I have always had a sympathy for the little fellows, so in this instance I will do it again. We have been very liberal in financing big business and monopoly in this country, and I think we ought to be able to render a little aid to the medical schools.

Mr. CARMICHAEL. It is interesting, is it not, that New England except for a little part of the money in the school at Vermont that does not provide from the State treasuries any money for dental education at all, and only that small amount for medical education. It is unique.

Senator MURRAY. The American Medical Association, Council on Hospitals and Medical Education. Will the gentlemen representing the American Medical Association come forward.

STATEMENT OF HARVEY B. STONE, M. D., COUNCIL ON HOSPITALS AND MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY PERKINS, M. D., DEAN OF JEFFERSON MEDICAL COLLEGE; VICTOR JOHNSON, M. D., DIRECTOR OF MAYO CLINIC; AND DONALD G. ANDERSON, M. D., SECRETARY OF COUNCIL ON HOSPITALS AND MEDICAL EDUCATION

Dr. Stone. Mr. Chairman, I am Dr. Harvey B. Stone, of Baltimore, Md. I have practiced surgery and served on the faculty of the Johns Hopkins University School of Medicine for 40 years. My official position with the American Medical Association is that of a member of the association's council on medical education and hospitals. This council consists of seven leaders in medical education under the chairmanship of Dr. Herman G. Weiskotten, dean of Syracuse University College of Medicine.

I am accompanied by Dr. William Harvey Perkins, dean of Jefferson Medical College of Philadelphia; Dr. Victor Johnson, of Rochester, Minn., director of the Mayo Foundation for Medical Education and Research; and Dr. Donald G. Anderson, of Chicago, former dean of Boston University School of Medicine and at present the executive officer of the council on medical education and hospitals of the American Medical Association.

With your permission, Senator Murray, I should like to call upon Dr. Anderson at this time to introduce our testimony.

Senator Murray. Dr. Anderson, you may proceed.

Dr. Anderson. The Council on Medical Education and Hospitals, and its predecessor, the Committee on Medical Education, has functioned for a century. The work of the council has been a major factor in establishing and maintaining the high standards of medical and hospital care in this country. The quality of a physician's services can be no better than the quality of the education he receives as an undergraduate in medical school and later as a hospital intern or resident. Early in the present century intensive efforts to improve medical education in this country were initiated. Some of the medical schools were still operated primarily for the financial profit of the faculty and provided exceedingly inferior instruction. At the instigation of the council, the Carnegie Foundation conducted a survey of medical schools, under the direction of Abraham Flexner and with the collaboration of representatives of the council. The findings in this survey, constituting the classic publication generally known as the Flexner report, resulted in the closing of a number of inferior schools. These were schools scarcely deserving the name and produced graduates obviously unqualified to treat the sick. The effect of the Flexner report was remarkable since the report was not supported by legal or governmental authority, but produced results entirely through its influence on public opinion.

Through the ensuing years to the present time, the recommendations of the Council on Medical Education and Hospitals still derive their effectiveness, not from legal authority, but from public opinion, lay and professional. This opinion recognizes the objectivity of the conclusions of the council in its efforts to improve medical education and as a consequence the quality of medical care.

Both bills under consideration by your committee today are of fundamental concern to medical education in this country. Each bill provides for the allocation of funds by the Federal Government to assist the medical schools in maintaining and expanding their present educational programs. There are many good reasons for being concerned about the participation of the Federal Government in the financing of medical education. It means a further intrusion by the Federal power into another field of private activity. It means another charge against the Federal Treasury when some in the Government are urging economy and others an increase in the tax rate. Whatever our views as citizens may be, we will limit our discussion today to the effect of this proposed new assumption of Federal responsibility on medical education and medical care. Dr. Stone will comment on the specific provisions of these bills. I would like at this time to discuss briefly the general problems of the financial support of medical education.

Medical education is the most expensive type of professional training, as many have already testified.

For many years the American Medical Association, through the Council on Medical Education and Hospitals, has been urging that adequate financial support be provided the medical schools of the country so that they would have the staff and facilities to offer the highest type of training which modern science makes possible. Satisfactory medical education can be provided only by institutions that have sufficient funds to employ competent teachers and to build, equip, and maintain laboratories for teaching and research. Our knowledge of disease and its treatment, while still incomplete, has advanced to the point where only physicians who have had the benefit of a sound education in the fundamentals of medical science should be entrusted with the lives and health of our citizens.

The sums expended by the individual medical schools for the education of a single student vary from close to $1,000 to more than $5,000 annually. No school can charge student fees that will meet the cost of maintaining such an expensive program for instruction. A recent study by the Council on Medical Education and Hospitals revealed that student fees provide only 25 percent of the total funds needed to operate our medical schools. The balance of the funds used in operating the medical schools is obtained from income on endowments, other university funds, gifts, and taxes.

There are seventy-two 4-year medical schools and seven schools offering the first 2 years of the medical-school course in the United States today. Of these, 32 institutions are State supported, 3 are municipal institutions, 1 institution is supported by the Federal Government, and 43 are private institutions. Of this latter group, the six medical schools in Pennsylvania receive substantial aid from State funds.

The medical schools have not been entirely unsuccessful in improving their financial condition in recent years, as witnessed by the testimony a few moments ago of President Carmichael.

Thus the total of the budgets of all the medical schools in the country today is somewhat more than twice the amount that was expended by the medical schools 15 years ago. Despite this increase, practically all medical schools require additional funds if they are to make maximum use of their present facilities and if they are to offer educational programs that approach the ideal.

As might be expected, the need for such additional funds and the use to which they would be put vary widely from institution to institution. However, the major utilization of those funds can be classified under four general categories:

1. The employment of additional instructors to provide more individual supervision and instruction;
2. The raising of salaries of present faculty members to permit them to continue their careers as teachers;
3. The renovation and modernization of laboratories and other facilities;
4. The construction of new facilities.

An accurate estimate of the total amount of additional money needed by the medical schools can be computed only after each school has made a detailed study of its needs. Some schools have already carried out such studies; others have attempted to estimate their financial needs in general terms.

The Survey of Medical Education sponsored by the American Medical Association and the Association of American Medical Colleges was initiated early this year and will extend over the next 3 years. It will involve a visit and detailed study of each medical school.

One of the objectives of the survey will be to stimulate schools to make precise estimates of the funds that they need to complete the development of their present program and estimate the funds required for the maximum expansion of their facilities consistent with efficient operation.

An inquiry conducted last summer by the council revealed that for the fiscal year ending June 30, 1949, the budgets of the medical schools totaled approximately $51,000.000. At the same time the schools reported that they estimated their need for additional funds for operating purposes at between $10,000,000 and $15,000,000 a year.

The figures just quoted represent funds that the schools require to stabilize and perfect their present programs.

I would emphasize a point that has already been emphasized, I think, by each speaker this morning. If the quality of medical education is to be preserved, the schools must be provided with sufficient funds to correct deficiencies in their present programs before they undertake to train an increased number of students.

Senator MURRAY. Doctor, do you think it is going to be difficult to work out some formula that would apply to all of the medical schools, so that each one of them could be provided with an adequate assistance to enable them to carry out this program?

Dr. ANDERSON. I think, sir, that any legislation should provide for the schools on a comparable basis, all the schools.

Senator MURRAY. Yes.

Dr. ANDERSON. What each school can do in the way of increasing facilities or increasing the number of students with a given amount of money or money provided by a given formula will vary because their bottlenecks vary in their magnitude. But I do think if the Government is going to aid, all schools could expect to be treated by a comparable formula.

Senator MURRAY. And that is not an easy thing to accomplish.

Dr. Anderson. No, sir.

Senator Murray. There is where we need you help when we finish the hearings.

Dr. Anderson. We are coming to suggestions concerning the type of formula to be used.

Without such assistance, straining their present inadequate staffs and facilities in an effort to train more students will result in a deterioration in the quality of medical education and ultimately of medical care. Any legislation providing Federal assistance to the medical schools should first allocate sufficient funds to the schools to bring their present programs up to higher standards. Funds to stimulate expansion should be provided only after the need for maintenance has been adequately met.

While there are many indications that the country could use more physicians, the insufficiency of our present production of physicians has been exaggerated in certain quarters. For the past 20 years the physician population of the United States has been increasing at a relatively more rapid rate than has the general population. As a result, this country today has more physicians per unit of population than any other country except Israel, where a great number of displaced physicians are concentrated.

All indications are that this trend will continue. In the past 7 years six new medical schools have been established. Several States now have under consideration the establishment of additional schools. A number of the existing schools have secured increased financial support that will enable them to increase their facilities and to accept additional students in the immediate future.

Official statistics on the total enrollment in the freshman class in the medical schools this coming fall will not be available for several weeks. On the basis of informal reports, it would appear likely that this class will be 5 to 10 percent larger than similar classes in the past. This increase represents the annual output of graduates of at least six new medical schools, if they were to be established.

In evaluating the question of physician shortage, we must recognize that approximately 5,000 physicians who graduated from medical school just before or during the war and who in the normal course of events would by this time have finished their graduate training and entered practice are still completing their residency training which was interrupted by the war. When the majority of these physicians leave their hospital positions within the next year or two to enter practice, many communities now faced with a shortage of physicians will experience definite relief.

In many respects the problem of the supply of physicians is more specifically a problem of distribution rather than of the over-all number. Increasing the number of physicians graduated annually would not of itself reverse the trend for physicians to settle in urban areas. This trend has been most marked during the past 20 years—a period when the over-all supply of physicians has been increasing. This trend must be combated by specific measures to increase the attractiveness of practice in rural areas, such as the Hill-Burton Act, as well as local community effort to provide conditions that will attract physicians.

The high quality of medical care enjoyed by the people of the United States today is basically the result of the improvements in medical education that have taken place in this country during the past 40 years. Two well-trained physicians have a greater potential for rendering effective medical care than do three inadequately trained physicians. To dilute the quality of medical education by urging or inducing the medical schools to increase rapidly the volume of students beyond the capacity of the schools to offer a satisfactory quality of medical education would, in the long run, defeat the objectives of a program initiated for the specific purpose of improving the health of the American people.

While additional funds could be put to good use by all medical schools and are urgently needed by some, all medical educators are agreed that the sacrifice of academic freedom would be too high a price to pay for such funds. Although many improvements are possible in medical education, the standards of medical education in the United States today are still very high. Furthermore, medical education is in safe hands. No other professional group has assumed responsibility more effectively in the education of its members than have the physicians of our Nation. If Federal officials are to be empowered to regulate, directly or indirectly, the curriculum, the administration or the admission policies of the medical schools, medical educators have emphatically indicated that they do not wish Federal support.

Senator Murray, with your permission Dr. Stone will continue.

Senator MURRAY. All right, Dr. Stone.

Dr. STONE. The unknown implications and consequences of Federal aid are a cause for concern. It is clearly recognized that the Federal Government has a definite responsibility to supervise the spending of public money. Many question whether such supervision can be accomplished without opening the door to Federal control of many important activities of the medical schools.

Senator MURRAY. Why is there any fear of Federal control?

Dr. STONE. May I read along a little further?

Senator MURRAY. Yes; you may.

Dr. STONE. It may be maintained that the Federal Government has for many years contributed to the support of the land-grant colleges without interfering with the policies of those institutions. Furthermore, the Federal Government has supported scientific research in recent years without interfering with the freedom of the individual research worker. There is a question, however, whether the experience with Federal support in these areas can be accepted as defining the pattern which will be followed in dealing with the educational program of the medical schools.

Senator MURRAY. We have also aided in expanding hospitals in the country and establishment of clinics.

Dr. STONE. That is quite true, sir.

Senator MURRAY. And research. And we have never interfered with the manner in which those activities were carried on. Is that not true?

Dr. STONE. That is true to the best of my knowledge.

Medical education is intimately related to medical care, which promises to be the subject of intense political discussion for some time to come. It is conceivable, therefore, that if the Federal Government should acquire the power to supervise the medical schools, the conduct of medical education might be subjected to adverse regulation in an attempt to alter the Nation's over-all program for providing medical service.

You asked me what we were afraid of and I am trying to tell you now.

Senator MURRAY. Yes.

Dr. STONE. Much of the concern about Federal aid to medical education would be removed if the basic legislation providing such aid could be written so that no Federal official, through the promulgation of regulations, could exercise direct or indirect control over the activities of the medical schools.

Senator MURRAY. I think that would be a very simple thing to do.

Dr. STONE. We hope it is simple and we insist it be there.

No Federal official, nor any body created by him, should have the power to determine academic standards or to decide which schools should be eligible for Federal aid. Otherwise the control of medical education would inevitably and unmistakably be centralized in Washington. It is imperative that the supervision of academic standards be kept in the hands of the medical schools, the profession, and the States. This objective could be achieved if the basic legislation contained a declaration that any medical school shall be eligible for financial aid if three-fourths of the States, through their medical licensing authorities, judge the school to be conducting an educational program of sufficiently high quality to warrant the admission of its graduates to the State examinations for medical licenses. May I interpose there. You asked me a while ago what we might be afraid of. If I could expand that last sentence and explain what is back of it. There is a possibility that the provision of funds for medical education, and particularly emphasis upon the erection of new schools, might lead to the development of schools which were quite improper in their capacity or quality of education. That is a detail which might come up for consideration in the conference which I understand is to be next week. But if there were provisions that no school would be eligible for Federal assistance unless its graduates were acceptable to three-quarters of the State licensing boards, that would remove one of the sources of apprehension.

Senator MURRAY. Suppose some of these State licensing boards would establish some requirement that would be different from what the medical profession had been recognizing in the past. Suppose they began to think that chiropractors would be able to render very valuable service to the people and they wanted to give preference to chiropractors.

Dr. STONE. It is not likely that three-quarters of them would do that.

Senator MURRAY. You do not think so?

Dr. STONE. I hardly think so; not, sir, unless the chiropractors raised their standard of education to where is was indistinguishable from a good medical education by the medical schools, and if they did that there would be no objection.

Another concern about Federal aid to medical education relates to the effect that it will have on local support of medical schools from both private and public funds. This has been touched upon by nearly every one of the previous witnesses this morning.

To prevent any possibility that the Federal Government may eventually be required to assume the full responsibility for medical education, Federal funds should not be made available to a degree that will diminish the local responsibility for the support and establishment of medical schools. In other words, we do not want Federal funds to let out the responsibility of the local people.

Senator MURRAY. Surely; I agree with you completely.

Dr. STONE. It is suggested, therefore, that no matter what formula is used for determining the amount of Federal aid provided, the total sum provided any individual school should in no case constitute more than 30 percent of the school's total budget.

That is merely a suggestion which will prevent the local financial support from withdrawing.

The question of providing Federal assistance for construction would appear to be a complex one. Many schools need funds for modernizing and renovating their existing buildings more urgently than they do for new construction. To promote the most economical use of funds and to make certain that no school is denied assistance that it needs, any provision for funds for construction should recognize this circumstance. In other words, the provision should be made that construction need not necessarily be new construction, that the construction funds can be utilized for the improvement and rehabilitation of present structures and not necessarily confined to the production of new construction. It is difficult to see how a satisfactory objective formula for furnishing funds for construction can be developed. But I think it can be done, no doubt. It should be given careful thought.

Senator MURRAY. I will have to ask you to suspend for a few minutes, I have to go to the Senate floor.

(Short recess taken.)

Senator MURRAY. You may proceed.

Dr. STONE. On the subject of scholarships, all medical educators are agreed that there should be adequate scholarship aid available to those young people who offer real promise but who are financially unable to undertake a program of medical education. Many medical educators, however, are opposed to establishing the requirement that in return for such scholarship aid, a student must agree to practice medicine in a designated area or to serve with a Federal agency for a given period of time after completion of his medical education. Such proposals represent a regimentation of the students, which is entirely unjustifiable.

Senator MURRAY. Doctor, if the student has the privilege of repaying the institution for his education, would that be satisfactory?

Dr. STONE. I hardly think so, sir, because that privilege might be a privilege on paper only. Most of these young men accept or receive scholarships because of their financial straits. Now it is not likely that a boy going through medical school would be in a better position to repay his loans when he graduated than he was when he started, and if he is not able to repay his loan at the time of his graduation, he is then due to serve his time, which he contracted for. In other words, he does not have an opportunity to recoup his financial status before he has to serve the time.

Senator MURRAY. If the term he would have to serve would be limited to, say, 2 years, what do you think?

Dr. Stone. I do not believe it is a question of the time he is limted to.

May I proceed with the next paragraph?

Senator Murray. Yes.

Dr. Stone. At the time a student is admitted to a medical school, no one can foretell what his interests and potentialities will be upon the completion of his medical course. To force a potentially great teacher, administrator, or research worker to discontinue his training and serve several years in rural practice or in Federal service is a disservice to humanity. The first few years after graduation from medical school are undoubtedly the most important years of a physician's career. To regiment a student for these years before he has even initiated his medical studies—that is before he enters medical school he has to agree to this—would appear to be both unwise and unfair to the student. One of our large philanthropic foundations has experimented with such a program and found it to be unsatisfactory and unsuccessful. That was referred to by one of the other witnesses this morning and it is a matter of actual record.

As a question of sound academic practice, under any scholarship program, the selection and supervision of the students receiving aid must be vested in the school responsible for their education.

I would like now to comment on the specific provisions for the support of medical education contained in title I of S. 1679 and title VI of S. 1581.

Senate bill 1679 places disproportionate emphasis on assisting the schools to increase their enrollments and insufficient emphasis on aiding the schools to strengthen and improve their present programs. This is clearly reflected in the formula set forth for calculating the payments to the schools for the cost of instruction. This formula—top of page 13—provides that a medical school will receive $300 for each student enrolled up to its average past enrollment, and $1,700 for each student enrolled in excess of its average past enrollment. Under a further provision of this bill—page 15, lines to 20—now medical schools would be greatly favored over existing medical schools since new schools would receive $850 for every student that they enrolled.

That, again, sir, brings into consideration the matter I spoke of before, the fear that some people entertain, and I share that fear, that a bill might be enacted into law which would put a financial premium on the development of inadequate or undesirable schools. This is simply emphasizing again that danger.

Senator Murray. Of course, I suppose they would require certain standards before they would finance a new school. They would not merely give money to an institution because it called itself a medical school; it would have to establish standards.

Dr. Stone. I should think so, certainly. But at the same time it does seem to us at least that this spread between the support for students in being and the inducements for prospective students is too wide a spread.

Senator Murray. You may proceed.

Dr. Stone. That covers practically the next paragraph which will be omitted.

The bill provides that payments to the schools for costs of instruction shall not exceed 50 percent of the amount determined to be the instructional budget in any school for any given year. As I have already indicated a ceiling of this type is highly desirable, but, in the interest of maintaing local support and responsibility, it would appear advisable to set the ceiling at 30 percent instead of 50 percent.

The section providing for grants for construction and equipment requires that the Surgeon General consult with the National Council on Education for Health Professions before making grants but leaves entirely to the discretion of the Surgeon General the actual awarding of such grants—page 17, lines 14 to 19. This provisions is especially dangerous. It would expose the Surgeon General to undue pressures and it vests in one man the power to decide for the entire country where additional construction needs are most urgent.

It would be our idea that this Council should not merely be a consulting body but an advisory and proposing body. In other words, its functions should be somewhat modified.

Under the section on conditions for grants—page 19, lines 13 to 15—it is required that the school give adequate assurance that it does not and will not impose any unreasonable restrictions against the admission of out-of-State students. The statement "unreasonable restrictions" is vague and would appear to permit the Surgeon General to influence the admission policies of a school by the interpretation he chose to place on this phrase.

The section on conditions for awarding of scholarships—page 28, lines 4 to 23—requires an appointee to agree upon completion of his training to practice in an area designated by his State agency or in a medical agency or unit of the United States giving 1 year for every two academic years during which he received the benefits of a scholarship. I have already pointed out that such provisions constitute unwise and unjustified regimentation of youth. Furthermore, the machinery set up for administering the scholarships is cumbersome and may open possibilities for undesirable pressures.

Without going into details, sir, the bill, as I recall the details, allocates scholarships by States. And the applicants for the scholarships are to be approved by the States under some selective mechanism which they set up before the man has even been accepted by a medical school. Our feeling is that the process should be reversed. These are suggestions for the detailed consideration of these bills. We think the man ought to first qualify as an acceptable student to a medical school before he is given a scholarship.

The section on regulations—page 30, lines 18 to 22—does not specify who will make the regulations but implies that they will be made by a Federal official who must consult, but who will not be bound by, the National Council on Education for Health Professions. Accordingly, full authority for establishing regulations which directly and indirectly may limit the academic freedom of the schools will be vested in the hands of one individual.

This bill, page 31, provides for the creation of a National Council on Education for Health Professions. It is, of course, highly desirable that any Federal official who administers a program of Federal aid to medical education should have an advisory council. This council should be given more authority than that assigned to a consultative body and should have broad representation from the field of medical education. As presently proposed—top of page 32—the council would have 10 members representing 5 fields of professional education. Presumably, this would permit only two representatives of medical education, as contrasted with dentistry, nursing, public health, and sanitary engineering.

This appears to be further concentration of power in the hands of a few individuals. Any activity as complex as medical education should have at least five representatives at the top policymaking level or advisory level.

It would seem—as a suggestion for consideration later—that this advisory council might be divided into five sectors of equal status, each one of which dealt with its own particular field, instead of having a common council dealing with all fields and only with a few representatives from each one.

This next is a change in our topic of discussion. With respect to S. 1581, the so-called Taft bill, the general comment can be made that this bill specifically recognizes that the need for Federal assistance may be temporary, that more adequate information should be obtained than is now available with respect to the Nation's need for manpower in the health professions, and that the greatest need of the medical schools is for assistance in providing more adequately for their present student bodies. These are commendable features and deserve support.

The section dealing with payments to the schools—page 56, lines 11 to 15—by providing that the sum of $500 be paid for each student enrolled in a school up to the average past enrollment of the school and that the sum of $750 be paid for each student in excess of the average past enrollment would appear to meet the essential needs of the schools and of the Nation in a more acceptable manner; that is, the differential is not as great here.

This bill, however, also vests in a single official, in this instance the National Health Administrator, authority to establish regulations with which the medical schools must comply to become or remain eligible for payments—bottom page 56, top page 57. Again it must be commented that such a provision places in the hands of one man rather wide control over the conduct of medical education.

This bill does not provide for any advisory council. The desirability of having such a council has already been commented upon.

No provision is made in the bill for placing any ceiling on the proportion of a school's budget that may be furnished by Federal funds. We again suggest that those funds be limited to 30 percent of the instructional budget.

As in S. 1679, it is stated that the schools must give adequate assurance that they do not and will not impose any unreasonable restrictions against the admission of out-of-State students without defining what is meant by the phrase "unreasonable restrictions"—page 57, lines 3 to 5).

It would seem in both bills that the provision might be tightened up and made more specific.

This bill would appear to postpone wisely provisions for grants for construction until a thorough study of the needs for such assistance has been made—bottom page 53, top page 54.

I should like to summarize my testimony by saying that there are many reasons for hoping that Federal aid for the support of medical education may not be necessary. Should it be decided that Federal support is the only means of preventing a grave impairment of both the quality and the extent of the facilities available in this country for medical education, it is to be hoped that the basic legislation providing such aid will contain adequate and unmistakable safeguards.

I would like to interpose in answer to some of your questions earlier: This is our concern, that we can see in the legislation adequate and unmistakable safeguards.

These safeguards should insure the preservation of academic freedom and protect the medical schools from political or governmental interference in planning their curricula, in establishing administrative policies, and in the selection of students. This can best be accomplished by establishing objective formulas, in the basic legislation, for the payments to the medical schools. The basic legislation should also limit the responsibility and authority of the officials administering the act to an audit which will determine that the funds are being used for the general purposes for which they were granted.

The formulas that are adopted for computing the payments to the schools should reflect the fact that Federal aid to medical education will be most effective in improving the Nation's health and medical care if such support is directed to stabilizing and improving our present program of medical education.

Continuance of local responsibility for the support of educational institutions should be assured by limiting to approximately 30 percent the contribution of the Federal Government to the expense of any one institution.

In the desirable attempt to prevent the exclusion of students on the grounds of discrimination based on race, creed, color, national origin, or place of residence, care must be taken that standards for admission based on adequate collegiate preparation, character, intellectual ability, physical fitness, and personality suitability are not lowered.

Any program for scholarship aid must contain no provisions that will in effect regiment youth. The administration of such a program must rest in the hands of the schools responsible for the education of the recipients.

The medical schools of this country, under the guidance of competent medical educators, have served the people well for many years. They have given the United States the largest number of physicians and the best-trained physicians of any country in the world. The preservation of their independence and freedom is basic and essential to any program for improving the health and medical welfare of the American people. It is hoped that the Congress will recognize and respect this principle in enacting any legislation that may bear on the field of medical education.

Only if the weight of the evidence presented to your committee during these hearings definitely indicates that Federal financial support of medical education is imperative and only if legislation consistent with the principles that we have outlined and containing the safeguards that we have mentioned can be enacted, would the American Medical Association be willing to endorse a trial of Federal aid to medical education.

I thank you. May I ask that my associates be given an opportunity to make any comment they would like?

Senator MURRAY. Certainly.

Dr. JOHNSON. I do not think I care to add anything at all to what Dr. Stone has said except to endorse what he has said. Thank you.

Senator MURRAY. Dr. Perkins?

Dr. PERKINS. I would like to refer back to one point which has been brought out a number of times in our discussion, in regard to the multiple support given to our medical schools. It has been brought out a number of times, and in our report here, that out of the 45 State schools, 3 municipally owned and operated schools, and 6 State-aided schools receiving public funds, that it leaves a residue of 30 or more schools which receive nothing from government funds, local or otherwise.

You yourself, Senator, have pointed out the great difference between the States.

Senator MURRAY. Yes.

Dr. JOHNSON. And we have been discussing the total amount to be allocated to support them from the Government limited to 30 or 50 percent.

Dr. PERKINS. I want to reiterate the great desirability of placing the responsibility to as great an extent as possible on the citizenry of a State.

I happen to come from the State of Pennsylvania which is unique in its constitutional provisions that it can allocate public funds in support of these private institutions. And I can say that the generosity of the State legislature under that provision has enabled us to increase the amounts of our total budget very considerably. For the biennium 1941–43 they gave us $90,000 per annum for our school. This year the Governor has just signed his budget for our school of $436,000 for the year.

Senator MURRAY. What medical school is that?

Dr. PERKINS. Jefferson Medical College. And that applies to all of the schools in that one State, and I think it is a principle worth emphasizing and studying to see whether or not more of the responsibility cannot be put on the local government.

Senator MURRAY. Of course, that is a wealthy State, and you could not expect such contributions from some of the backward States of the country, could you?

Dr. PERKINS. Not proportionately; no, sir.

Senator MURRAY. Pennsylvania is highly industrialized and would be very well able to contribute to the medical schools. But some of the sections of the country like Mississippi or some of the Western States would have great difficulty.

Dr. PERKINS. Yes.

Senator MURRAY. Of course, we have no controversy here in this committee whatever on this subject of medical education. What we want to do is try to work out a bill that will be as perfect as possible, and we want the assistance of the medical departments and heads of the medical schools in trying to accomplish that.

I do not think that anyone here wants to have anything in this legislation that would enable the State to exercise any undue influence in medical education or take any course that could be detrimental to good, sound medical education in the country.

Any other comments?

Dr. STONE. I would like to thank you for our hearing and say again, as Dr. Hinsey said, how gratified we are that there is to be a working hearing on details. You will observe that much of what we had to say dealt with individual items and not with the basic principle.

Senator MURRAY. I think that will be an important contribution to the committee. Thank you, Doctor.

We will recess until 10 o'clock tomorrow morning.

(Whereupon, at 12:30 p. m., the committee recessed, to reconvene at 10 a. m. Tuesday, June 7, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

TUESDAY, JUNE 7, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:10 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senator Murray.

Senator Murray. The hearing will come to order.

The first witness this morning will be a panel of four headed by Brig. Gen. James Stevens Simmons. Will you take the stand, gentlemen.

Dr. Simmons. Senator Murray, this is Dr. Ira Hiscock, chairman of the department of public health of Yale Medical School, and Dr. Gaylord W. Anderson, who is director of the School of Public Health of the University of Minnesota.

I am sorry Dr. Lowell J. Reed, from Johns Hopkins, has not arrived yet, and Dr. Harry Mustard, dean of Columbia University School of Public Health, was supposed to come.

Senator Murray. He was to be here this morning?

Dr. Simmons. Yes, sir. Something must have happened to the train.

Senator Murray. If he does not get here and has a statement, we will have his statement printed in the record.

Dr. Simmons. Thank you.

Senator Murray. So you may proceed, Doctor, and if any other members of your panel come in in the meantime, we will hear them.

STATEMENT OF JAMES STEVENS SIMMONS, M. D., DEAN OF SCHOOL OF PUBLIC HEALTH, HARVARD UNIVERSITY; ACCOMPANIED BY GAYLORD W. ANDERSON, DEAN, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MINNESOTA; AND IRA HISCOCK, CHAIRMAN, PUBLIC HEALTH DEPARTMENT, YALE UNIVERSITY

Dr. Simmons. Thank you, Mr. Chairman.

The Association of Schools of Public Health, of which I am president, is grateful for this opportunity to testify on title I of Senate bill 1679, and title VI of Senate bill 1581.

The association represents all the schools and departments of public health in universities of the United States accredited to give postgraduate training in this important field. These institutions serve the Nation as special educational centers for health personnel. They maintain the advanced training facilities required to produce health experts and leaders for planning, organizing, directing, and operating such programs of public health as may be adopted by our Nation.

Thus we have a keen interest in the various health plans your committee is now considering. Regardless of what plan may be adopted, we wish to emphasize the necessity of making adequate provision for training all the professional manpower required to operate an effective total health program.

It is the purpose of my testimony to indicate the contribution which our schools are qualified to make to such a program, and to recommend the necessary financial support.

We all agre that public health is concerned with the prevention of disease and the development of optimum physical and mental health. Primarily it includes those preventive activities which are recognized as a community responsibility—from sanitation, nutrition, and hospital administration to the control of diphtheria and cancer. Public health today is our greatest hope for the future elimination of virtually every disease, including many of the afflictions of old age.

To sum it up, public health is the science of keeping people well.

With this in mind, let me tell you something about the schools I represent:

The nine schools or departments of public health in the continental United States are located at the Universities of California, Columbia, Harvard, Johns Hopkins, Michigan, Minnesota, North Carolina, Tulane, and Wale. They are accredited by the American Public Health Association to give training leading to the degrees of master or doctor of public health, or master of science.

Established within the last three decades, these schools are dedicated to a new concept of service through adding to the Nation's facilities for medical training an entirely new type of institution devoted to postgraduate training in public health. They were conceived and designed to supplement the humane services of curative medicine and to provide effective postgraduate instruction in the modern techniques of wholesale community disease prevention and health conservation.

Their objective is to control disease on a broad scale and to bring better physical, mental, and social health not just to the individual, but to large masses of people.

The schools approach this objective through integrated programs of postgraduate instruction, research, and community service. These programs are designed to produce the expert specialists required, (*a*) for community and national health; (*b*) for the health of industry, both labor and management; and (*c*) for international health agencies. They train administrators for general health programs, and specialists for programs in industrial health, maternal and child health, mental hygiene, and for the control of cancer, venereal disease, tuberculosis, and tropical diseases. Other important functions include the training of administrators of hospitals, clinics, and service programs, and teachers for schools of public health and departments of preventive medicine in medical schools.

The training programs provided by the different schools vary. However, they all emphasize the postgraduate training of students who are already qualified in various branches of science important to public health, particularly physicians, dentists, or veterinarians. After one or more years of intensive training, these graduates go into the essential health positions already indicated. Many of them accept Government positions. Therefore, the schools of public health render a direct Government service comparable to West Point and Annapolis.

If the Nation's health program is to be expanded, we must have more experts of the types now being trained by these schools.

PERSONNEL NOW BEING TRAINED BY THE SCHOOLS OF PUBLIC HEALTH

During the academic year 1947–48, 655 students were enrolled in accredited schools. Of this number 482 were candidates for special degrees or certificates, which indicates a considerable increase over the annual output of the past 10 years. This is not sufficient even for present national needs, much less for the requirements of any expanded program.

NATIONAL TRAINING REQUIREMENTS

Recent estimates made for the association of representatives of the United States Public Health Service and various professional groups (see exhibit I) indicate that about 35,800 individuals are now engaged in full-time public-health work in the United States. Eighty percent of these are serving in official, and 20 percent in voluntary, health agencies.

Senator MURRAY. I suppose these schools furnish the trained experts in the field of mining, for instance, where they are studying the causes and ways of avoiding silicosis.

Dr. SIMMONS. Yes, sir; some of them.

Senator MURRAY. For a long time no attention was paid to that disease at all.

Dr. SIMMONS. That is right.

Senator MURRAY. And there was a very serious condition developed in the mining industry.

Dr. SIMMONS. Yes, sir.

Senator MURRAY. I know in my State, a great many miners I used to meet around the streets were suffering from this silicosis disease and were in the last stages of it.

Dr. SIMMONS. That is right. Several of the schools have departments of industrial hygiene. We have one at our school that has been there since 1921.

Only about one-third have had formal training in public-health schools or in other public-health training centers.

It is estimated that an adequate national program will require about 68,000 health specialists in 1960. This includes physicians, nurses, engineers, sanitarians, dentists, health educators, and laboratory workers. We must also provide medical-care directors, nutritionists, statisticians, and other public-health workers.

Thirty percent or 20,000 of this 68,000 will require advanced training of the type now available in the accredited schools of public health. To fill these 20,000 positions by 1960, and allowing for retirements and turn-over, the annual postgraduate training need will be at least 2,300 per year.

This is more than three times the total number of students who attended schools of public health in 1947–48, and about five times the number who received certificates and degrees that year. On this basis, the country's facilities for postgraduate health training must be increased for two reasons:

(1) To train new health personnel; and

(2) To train a portion of the personnel now employed in this field.

Such increased training can be provided either by expansion of the present schools or by such expansion supplemented by the establishment of new schools. In either case it will be necessary to determine the total cost of such expansion and to make adequate provisions for financial support.

THE SCHOOLS OF PUBLIC HEALTH TODAY

The financial situation of the schools of public health today is not satisfactory. Practically all of them need additional funds even to stabilize current operation. Recently, one of the accredited schools was forced to close because of lack of support, and only a few years ago another school was discontinued for the same reason. This year several schools report deficits ranging from $50,000 to $290,000. Obviously new funds must be obtained in order to continue satisfactory operation during 1950 and subsequent years.

If these schools are to increase the supply of the Nation's health specialists, they must have additional financial support. Without this support they cannot provide the teaching staff, the space, and the equipment essential to the expansion obviously required.

A preliminary study of the financial requirements (see exhibit II) of the schools was recently made to determine how the Government might help most effectively to stabilize and insure present operations and to increase the future output of specialists without decreasing the quality of their instruction. Reports from the deans of the nine schools show the total operating expenses to be about as follows: 1948, $2,640,000; 1949, $2,997,000; 1950, $3,275,000. The approximate distribution of these costs is as follows: direct institutional costs for construction, 74 percent; administrative and general expenses, 14 percent; plant operation and maintenance, 11 percent; libraries, 1 percent. These figures do not include the cost of special research projects, estimated at a million and a half dollars for the fiscal year 1949.

PRESENT SOURCES OF INCOME

The income with which to meet these basic expenses is derived from various sources of which tuition is a relatively minor item. In 1950, the average annual income from tuition will be about $440 per student. The cost per student will be approximately $4,500. Thus, tuition covers only about 10 percent of the total educational operating expenses.

Other sources of income are State appropriations, endowment, general university funds, and various temporary and restricted gifts for current use. The latter must be continually replaced in order to keep the schools running. To secure replacements, puts undue demands on the time of our teaching staffs, and constitutes a difficult and precarious method for keeping these schools in operation.

At our school, for example, about 25 percent of what we call firm and semifirm income is derived from a small endowment plus tuition, and the other 76 percent is from what we call "soft" money. It is temporary grants, small grants that have to be renewed in 1 year, 2 years, 3 years, or 4 years, and it means a continuous search for replacements for those funds. It makes it very difficult to employ competent men of the caliber we need and give them security which they should be able to be given. That is on this basis.

A careful audit of the financial situation of each school will be required to determine its exact operational needs. However, from current reports submitted by the deans, it appears that most of the schools will require additional funds for future operations whether at present levels or under a program of expansion.

REASONS FOR GOVERNMENT SUPPORT

Whatever the situation in the future, it seems reasonable that the Federal Government should assist in financing the schools of public health.

First, all the schools, including those receiving State funds, draw their students from the country as a whole. Second, about 80 percent of the graduates of our schools enter Government service. Most of the others serve voluntary agencies, entire industries, labor organizations, or educational institutions.

In determining the amount of assistance required, it should be kept in mind that the financial needs of schools of public health differ considerably from those of the medical schools. Therefore, any plan for Federal support should provide a different formula for making aid available.

The annual cost of public health training is greater than the cost of medical instruction, on a per capita basis. The public health student requires an intensive postgraduate type of instruction; it must be individualized according to the varying needs and background of the student. The students, most of whom are already medical school graduates, must be taught in small groups on a seminar basis. Much material from medical, engineering, educational, and other diverse disciplines must be packed into a single year of training.

Another reason for the high cost of this type of training is the fact there is a shortage of teachers and professors, and the competition for them between various schools and various health agencies is keen, which normally runs up salaries. The faculty also has no opportunity as a rule to engage in the clinical practice of medicine as in medical schools. For example, in many medical schools clinical professors may make $50,000 to $60,000 a year in practice and draw very small salaries from a medical school. We cannot engage in that, at least we have not been able to so far. We have to insure the security of our faculties more and, therefore, that is another factor which runs up the cost.

All these factors increase the expense of public-health training. Since tuition covers only one-tenth of the operating cost, the addition of more students without increased financial assistance will only aggravate an already difficult situation.

PROPOSED METHOD OF PROVIDING FEDERAL ASSISTANCE

Various methods have been proposed for providing the schools of public health with funds to meet their obligations to the future health of the Nation. Senate bill 1679, one of the bills being considered at this hearing (Title I—Education of Health Personnel, pt. 2, sec. 372, par. 4, on p. 14) reads as follows:

> To each school of public health which provides training leading to a graduate degree in fields relating to public health (including hospital administration) $350 per each student enrolled for such training up to its average base enrollment and $2,400 for each student so enrolled in excess of its average base enrollment.

The base enrollment is to be an average of the three fiscal years 1947, 1948, and 1949. Application of this formula will, of course, assist the schools, but is not considered adequate to solve their financial difficulties, because of the relatively small amount which it provides for each student within the average base enrollment.

It should also be noted that the 3 years selected for determining "average base enrollment," represents a period during which considerable expansion has already been made without a comparable increase in the resources of the schools.

I should like to emphasize that by saying that the school with which I am connected, the Harvard School of Public Health, as in other schools, where we have felt that there was a great national need for more training in this subject and we have gambled in increasing our enrollment on the type of temporary money I mentioned before, hoping to stabilize our future operations by getting firm endowment or help from some other source. I think that is true of all the schools, that we had without any idea of getting Government money, felt there was something that should be done and we have tried to do it.

Senator MURRAY. You were urged to do that because of the necessity?

Dr. SIMMONS. Because we felt there was a national need, sir.

The provisions for construction and for scholarships in this bill appear to be adequate.

Senate bill 1581 makes specific provision for assistance to medical schools but not to schools of public health. However, we favor its provision for a survey of needs, and further suggest the inclusion of the schools of public health in this survey, plus adequate provisions for temporary aid.

At a recent meeting of the deans of the accredited schools of public health, a formula for Federal financial assistance was developed which was considered satisfactory both from the standpoint of the Government and of the schools. (See exhibit III.) This formula provided a per capita grant for an average number of students, a premium for additional students, and a block grant. Something approaching this formula is necessary to meet our needs, but it is realized that the application of any formula will require a careful study of the present and future financial requirements of the schools.

FUNDS FOR CONSTRUCTION

In addition to funds for basis educational operations, the nine schools of public health will need money for the construction required to expand their training facilities. An estimate made recently by the deans indicates that a building program costing approximately $20,000,000 would permit these schools to double present enrollment. Provisions for necessary construction are made in Senate bill 1679, but not in Senate bill 1581. To meet the existing needs of the schools, it is felt that both bills should include these provisions on at least a matching basis. I should like to emphasize that this amount of construction will take care of the need of the present schools only to double present enrollment, and that in order to carry forward the projected needs for 1960 for trained personnel undoubtedly additional construction money will be required.

FUNDS FOR SCHOLARSHIPS

Scholarships are needed so that more students can take postgraduate training in school of public health.

State health officers are now authorized to pay tuition, travel, stipend (up to full salary of position for which employed) and all costs incident to the training of personnel employed or to be employed in official State and local health agencies. However, such assistance is only available for State-sponsored training, and additional provisions are needed for the training of public health workers not eligible under this authorization.

This is important, gentlemen, because if we are to stimulate the development of all the health personnel we need we must attract the best type of medical students before he leaves medical school, preferably starting the first or second year. We should be able to give the young medical student a vision of a profitable career of service in public health similar to the type of vision he has for internal medicine and for surgery, and we should be drawing some of this best type of young man from the medical schools in addition to what we are getting now.

Senator MURRAY. That is not a very easy thing.

Dr. SIMMONS. No, sir. The crux of the thing comes down eventually to the grade of salaries we pay our Government health people.

The amounts of the scholarships for students in schools of public health should be larger than those for medical students. The average public health student is older than the average medical, dental, or nursing student. He has already had 4 years of medicine, 1 year of internship, and 1 year of residency before even applying for admission to our schools. As a rule, he is married, has a family, and considerable financial responsibility. Few public health students can even afford to pay their own tuition.

That is because of the type of salaries they get rather than being engaged in the lucrative practice of medicine. Therefore an adequate scholarship program should be provided.

The establishment of a loan fund has been suggested, but this will not solve our problem.

As a public servant the public health graduate cannot expect a substantial increase in earning power even as a result of his advanced training. He has little hope of repaying substantial loans. Unless money is made available in the form of scholarships or grants, there will probably be no increase in the number of applicants for postgraduate training.

The scholarship provisions indicated in Senate bill 1679 are considered adequate. We feel that the same provisions should be included in Senate bill 1581.

CONCLUSIONS AND RECOMMENDATIONS

In conclusion may I state that the schools of public health are eager to assist in the development of a national public-health program, particularly in training the expert health personnel which will be required. To perform this service the schools must have considerable additional annual income to expand their basic educational activities and capital funds for essential construction and equipment. Because of the nature of the science of public health, and the background required by its personnel, costs of instruction and training are higher than in any comparable profession. It is a fact that the schools of public health will be unable to accomplish the training of personnel required for any one of the public health programs now being considered by the Congress unless adequate Government aid is assured.

Unless this training is provided by our schools, the health of the people of this country will rest in the hands of personnel inadequate in numbers and deficient in training.

Specifically the Association of Schools of Public Health makes the following recommendations:

(1) That provisions be made for a study of the manpower requirements in the public-health profession, the training facilities, and the financial needs of the schools of public health.

This will require more careful study than we have been able to make in the short time available.

(2) That provisions be made for immediate interim or temporary payments to the schools of public health to enable them to maintain and increase enrollment during the period of the proposed study, this aid to be based on whatever formula meets the basic needs of the schools, and is acceptable to the Congress.

(3) That in the development of a permanent program of aid to public-health education the schools of public health which provide graduate training leading to degrees, including hospital administration, be given funds sufficient to meet the demands to which they will be subjected by whatever public-health program is adopted by the Congress.

(4) That there also be authorized, based on the proposed study, sufficient funds to provide the modern equipment and construction for the necessary improvement and expansion of existing facilities, and that these grants be authorized on a matching basis in accordance with needs of the schools concerned.

(5) That both the immediate and long-range programs of aid include provisions for Federal scholarships to graduate students in public health, including those not already holding positions in Government health departments; these scholarships to cover normal costs of tuition, educational fees, books, and equipment, and also to cover the costs of personal maintenance in whatever amount may be determined as the median for single students and students with dependents.

In closing, may I express to the members of this committee and to the Congress my personal appreciation and the appreciation of the

Association of Schools of Public Health, for the opportunity to present their opinions and recommendations. We are willing and eager to extend our services and to do everything possible to forward our joint objective of advancing the health of the people of the United States.

Senator MURRAY. The exhibits attached to your statement will be inserted in the record.

(The exhibits above referred to are as follows:)

EXHIBIT I

Fact Sheet

NATIONAL NEED FOR TRAINED PUBLIC-HEALTH WORKERS AND PROVISION OF ADEQUATE FACILITIES FOR ADVANCED POSTGRADUATE TRAINING BY SCHOOLS OF PUBLIC HEALTH

(Prepared at the request of the Association of Schools of Public Health by representatives of the USPHS in cooperation with the deans of the accredited schools and other professional groups)

1. Approved schools of public health

(*a*) In 1930 there were only four schools or departments (Columbia, Harvard, Johns Hopkins, Yale) in existence, which later were fully accredited when the American Public Health Association (APHA) inaugurated an accreditation program in 1945.

(*b*) There are today nine approved schools or departments in the continental United States (California, Columbia, Harvard, Johns Hopkins, Michigan, Minnesota, North Carolina, Tulane, Yale). Vanderbilt University had an approved school until the 1948–49 academic year, when it was discontinued for lack of funds.

2. Training data on schools of public health

(*a*) The number of graduate students enrolled in the approved schools in the United States during the 1947–48 academic year was 655.

(*b*) The number of graduates of schools of public health (approved and nonapproved):

Academic year:	*Number*	Academic year—Continued	*Number*
1930–31	119	1947–48	444
1934–35	113	1948–49 (estimate)	450
1939–40	303	1949–50 (estimate)	450
1945–46	323	1950–51 (estimate)	450
1946–47	453		

(*c*) Length of course: (1) One year of study generally is required for the master's degree. Two years are required for the master's degree in hospital administration. Two years are required at Harvard and Johns Hopkins for the master of science in hygiene degree.

(2) Two or three years generally are required for doctoral degrees in public health depending on the qualifications of the individual candidates.

3. Estimated number of full-time public health workers now active in the United States

	Year 1949
(*a*) Total (all professions)	35, 800
(1) Medical	2, 700
(2) Nursing	22, 000
(3) Engineering	1, 100
(4) Sanitation	5, 500
(5) Dental	360
(6) Health education	890
(7) Laboratory	3, 250

(*b*) Number of above total in official public health agencies: 29,500.

(*c*) Number in voluntary public health agencies: 6,300.

4. *Number of full-time trained public health workers needed by the United States in 1960*

(Based on estimated population of 160,000,000 and complete coverage of United States with local health units. Ratios for physicians and nurses are those recommended by APHA; others are based on standards recommended by experts in the respective fields—see explanatory note.)

	Year 1960
Total (all professions)	68,300
(1) Medical	5,000
(2) Nursing	[1] 35,500
(3) Engineering	3,300
(4) Sanitation	10,700
(5) Dental	1,450
(6) Health education	3,550
(7) Laboratory	8,800

[1] This figure should be doubled if a comprehensive nursing service, including bedside care, is to be provided.

The total, 68,300, is the number of health workers who should be on the job in 1960 in order to meet the needs outlined in the attached explanatory note. To provide this number of active workers in 1960 it will be necessary to train a total of 77,530 in order to make up for training deficiencies of existing personnel and to cover local personnel turn-over.

The following table shows the basis of the future training load to supply 68,300 active trained public health workers in 1960.

	New personnel		Estimated present employees needing further training	Total, 10-year period
	Estimated deficiency	Estimated replacements		
Medical	2,300	1,350	1,750	5,400
Nursing	13,500	22,000	15,180	50,680
Engineering	2,200	330	220	2,750
Sanitation [1]	1,040	1,650	830	3,520
Dental	1,090	180	240	1,510
Health education	2,660	450	300	3,410
Laboratory	5,550	3,900	810	10,260
Total	28,340	29,860	19,330	77,530

[1] Only 20 percent of the number of sanitarians now employed are used in computing training needs for sanitarians, since it is believed that only this fraction constitutes a training problem for professional schools.

5. *Full-time health workers to be trained by schools of public health*

Thirty percent or 23,250 of the 77,530 workers to be trained by 1960 should have advanced postgraduate training in schools of public health. This includes all of the physicians and dentists needed, but only a varying portion, in some instances quite small, of the other professional groups.

It should be noted that these figures do not include estimated needs for hospital administrators, medical care directors, nutritionists, statisticians, veterinarians, and other important specialists concerned with public health work. This is because no bases similar to those for the classes listed above have yet been developed for estimating future needs for personnel of these special types. Therefore, the total requirement for 1960 will probably be even greater than 23,250.

6. *Estimate of the expansion of present training facilities of approved schools of public health required to meet this goal in 1960*

This year 1948–49 the combined enrollment of the accredited schools of public health is about 800 students, of which about 450 are candidates for degrees or certificates. Another school is being developed at the University of Pittsburgh and will probably be operating by 1951. It is estimated that with adequate financial assistance for teaching staff, equipment, and construction, these 10 schools might conceivably expand sufficiently to take care of the training of the required 22,800 students if enrollment is increased gradually to about 3,000 per year by 1959–60, as shown in the following table.

Academic year:	*Enrollment*
1948–49	800
1949–50	1, 000
1950–51	1, 200
1951–52	1, 400
1952–53	1, 600
1953–54	1, 800
1954–55	2, 000
1955–56	2, 200
1956–57	2, 400
1957–58	2, 600
1958–59	2, 800
1959–60	3, 000
Total	22, 800

To reach this figure would require an average enrollment for each of the 10 schools of about 300 per annum by the academic year 1959–60. As their ability to reach this degree of expansion is subject to question, consideration should be given to the possibility of establishing a limited number of additional schools of the high professional quality suitable for accreditation. Some of these additional schools might specialize in the postgraduate training of nonmedical health workers.

[Explanatory note]

ESTIMATED REQUESTS FOR VARIOUS TYPES OF FULL-TIME HEALTH PERSONNEL TO SERVE THE UNITED STATES BY 1960

The estimates shown in the previous tables are based on an estimated 1960 population of 160,000,000. They assume complete coverage of the United States by local health units serving areas of sufficient population and financial resources for economical operation. They are based only on full-time personnel. The standards used as a basis for these estimates were as follows:

(The ratios for physicians and nurses are those recommended by APHA. The others are unofficial standards recommended by people of recognized standing in the respective fields.)

One public-health physician for every fifty thousand population except that each local health unit will have at least one public-health physician (plus State needs arrived at by projecting the ratio of public health physicians to population in the twelve States most adequately staffed to the entire country; plus a modest increase for Federal personnel).

One staff public-health nurse for every five thousand population and one supervisory nurse to every ten staff nurses for basis of public health nursing service at both State and local level (plus a modest increase in Federal personnel).

One sanitary engineer for every sixty thousand population (plus State and Federal needs as computed for physicians).

One sanitation worker for every fifteen thousand population (except that each local health unit will have one trained sanitarian; plus State and Federal needs as computed for physicians).

One public-health dentist to every one hundred thousand (however, it is assumed that units under fifty thousand population will not have a full-time dentist and that a number of the units serving populations of fifty thousand to eighty thousand will combine to use the services of a single dentist).

One health educator for every fifty thousand population (plus State and Federal needs as computed for physicians).

One laboratory worker for every twenty thousand population (to serve both State and local needs plus a modest increase in Federal personnel).

EXHIBIT II. FINANCIAL DATA ON ACCREDITIED SCHOOLS AND DEPARTMENTS OF PUBLIC HEALTH IN THE UNITED STATES

(Prepared at the request of the Association of Schools of Public Health by representatives of the USPHS in cooperation with the deans of the accredited schools and other professional groups)

A. COSTS OF OPERATING THE SCHOOLS OF PUBLIC HEALTH

TABLE I.—*Total educational operating expenses (not including research grants), graduate schools of public health, fiscal years 1948, 1949, and 1950*

Function	Total expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Instructional costs	$1, 916, 746	$2, 193, 518	$2, 429, 288
Administration and general expenses	375, 896	411, 834	453, 048
Plant operation and maintenance	312, 894	356, 976	354, 110
Libraries	35, 812	35, 437	35, 982
Total	2, 641, 348	2, 997, 765	3, 272, 428

TABLE II.—*Percentage distribution of total educational operating expenses, graduate schools of public health, fiscal years 1948, 1949, and 1950*

Function	Percentage of total educational operating expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Instructional costs	72. 6	73. 2	74. 2
Administration and general expenses	14. 2	13. 7	13. 9
Plant operation and maintenance	11. 8	11. 9	10. 8
Libraries	1. 4	1. 2	1. 1
Total	100. 0	100. 0	100. 0

A high percentage of the total operating expense (nearly 75 percent) is devoted to the productive function of instruction. This cost is irreducible if quality of training is to be maintained and if good teachers are to be attracted to teaching.

B. SOURCES OF FUNDS TO MEET OPERATING EXPENSES

In fiscal year 1948 student tuition and fees provided $291,933, or 11.1 percent of the total operating expenses of the schools of public health. Receipts from student tuition and fees during the present fiscal year will total only $312,930, or 10.4 percent of the educational operating expenses of the schools. It is estimated that the funds from student tuition and fees will not increase in fiscal year 1950 as the number of enrollees will be approximately the same as in fiscal year 1949.

The other sources of income are State appropriations, income from endowments, general university funds, and a number of small temporary gifts and grants for current use which expire in 1, 2, 3, or more years and must be constantly replaced in order to keep the schools running.

Privately supported schools

There are five privately supported schools—Harvard, Columbia, Johns Hopkins, Yale, and Tulane. Table III indicates the degree to which the operating costs of these private schools are met from the major sources of income.

TABLE III.—*Sources of income, privately supported schools, fiscal years 1948, 1949, and 1950*

Source of funds	Percentage of total educational operating expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Endowment income	35	31	32
General university funds	26	22	27
Temporary gifts and grants	25	34	27
Tuition and fees and miscellaneous	14	13	14
Total	100	100	100

The reported dollar contributions from general university funds and from the temporary gifts and grants are very considerable (51 to 56 percent of total income), and, as these sources are inconstant and tend to disappear, they are a difficult and uncertain method of insuring the future. Table IV indicates the part that the sources of funds play in meeting the operating expenses on a per student basis.

TABLE IV.—*Per student averages, privately supported schools*

Fiscal year	Operating expense, average annual operating expense per graduate student	Sources of income		
		Average annual income per student from tuition and fees	Average annual income per student from general university funds and temporary gifts and grants	Average annual income per student from all other sources
1949	$4,495	$447	$2,494	$1,554
1950	4,934	447	2,390	2,097

Endowed schools are presently experiencing difficulty in obtaining gifts and grants for instructional purposes and the schools of public health are receiving more than their proportionate share of university general funds. Unless new funds are made available, these schools will be faced with the alternative of either seriously curtailing their teaching program or spending their capital. This situation at endowed schools is particularly serious at a time when the schools should be expanding not only in the scope of the instruction offered but in the number of students trained.

State-supported schools

The schools of North Carolina, California, Minnesota, and Michigan receive income primarily from State appropriations. Table V estimates the degree to which the operating costs of these State schools are met from the major sources of income.

TABLE V.—*Sources of income, State-supported schools, fiscal years 1949 and 1950*

Source of funds	Percentage of total educational operating expenses	
	Fiscal year 1949	Fiscal year 1950
State appropriations	79	80
Tuition and fees	11	10
Gifts and grants and endowment	10	10
Total	100	100

Table VI estimates the part that the sources of funds play in meeting the operating expenses on a per student basis.

TABLE VI.—*Per student averages, State-supported schools*

Fiscal year	Operating expense, average annual operating expenses per graduate student	Sources of income		
		Average annual income per student from tuition and fees	Average annual income per student from State appropriations	Average annual income per student from all other sources
1949	$3,603	$404	$2,840	$359
1950	3,896	404	3,121	371

C. BUILDING COSTS TO MEET PROPOSED EXPANSION PROGRAM OF THE SCHOOLS [1]

TABLE VII.—*Cost of building program*

Harvard University	$4,500,000
The Johns Hopkins University	4,000,000
University of Michigan	3,000,000
Columbia University	3,000,000
University of California	2,250,000
University of North Carolina	1,500,000
Tulane University	425,000
University of Minnesota	350,000
Yale University	(²)
Total	19,025,000

[1] This program would permit an over-all doubling of present enrollment of all schools; however, it would fall far short of 1960 needs.

[2] New building needed; no estimate of cost available.

D. ADDITIONAL STATEMENTS ON PROPOSED EXPANSION PROGRAMS OF THE SCHOOLS

(*a*) *University of California.*—They are now housed in temporary quarters. They will need at least to double the California State Legislature's appropriation of $1,125,000 for their building fund if they are to carry their share and serve some 11 Western States and the neighboring nations. It is felt that Federal aid is absolutely necessary for this development.

(*b*) *Columbia University.*—Regarding additional needs, they have had plans tentatively drawn for a building program to house their activities in the school of public health which would cost approximately $3,000,000. In addition their operational budget would increase in the enrollment to approximately 250 graduate students.

(*c*) *Harvard University.*—Expansion program provides for training of from 150 to 200 students. In order to meet these needs the school has proposed to the university a financial program extending over a period of several years. In this program it is proposed to try to raise sufficient endowment so that the fixed income of the school will cover its fixed expenses. It is estimated that at least $12,000,000 additional endowment will be required to do this. It is also proposed that in order to house the expanded activities of the school 4½ to 5 million dollars be obtained from some source with which to construct a modern building.

(*d*) *Johns Hopkins University.*—The school estimates that to adequately meet the needs of the present number of students admitted to the school additional construction is necessary at the present time. School estimates construction needs to meet the space requirements of the present enrollment of the school in terms of a building costing approximately $750,000. They estimate need, in order to provide adequately for the present group, of an increase in the operating budget of approximately $100,000 per year and above the existing operating budget. If the enrollment of the school were to be doubled, they estimate their requirement of an approximate duplication of the present facilities at a cost of approximately $4,000,000. Doubling the class would, they believe, increase the operating budget by no less than $300,000 per year.

(*e*) *University of Michigan.*—Preliminary sketches are available for an addition to the school plant which will more than double the present capacity, with special emphasis upon laboratories in the fields of industrial health, sanitation, nutrition, and the important problems dealing with the aging process. Such an addition will permit an increase in the enrollment to approximately 250 graduate students. It is estimated that the new building, together with equipment, would cost approximately $3,000,000.

(*f*) *University of Minnesota.*—As an essential first step in expanding the capacity of the SPH at Minnesota, it is estimated that at least $200,000 per annum will be needed to meet the increased instructional program to be offered, and $350,000 will be needed for a building program to house the expanded activities of the school.

(*g*) *University of North Carolina.*—The university recognized the urgency of expansion of physical facilities to meet present as well as future public health training and has appropriated money for one wing of the new school of public health building which is now under construction and will be completed by July 1. They have given primary priority in their request to the North Carolina Legislature for building appropriations to complete the new school of public health at an estimated cost of $1,500,000 dependent upon Federal participation in the cost of construction. Such a Federal appropriation is necessary considering the large proportion of students of public health who come from and go to other States following their training in this institution.

With the completion of this new school of public health the quota of students can be increased to a total of 200 students. Such a program calls for roughly an increased annual teaching appropriation beyond present appropriations of approximately $300,000. With the probability that the proportion of North Carolina students served by this institution will not increase, it is obvious that the majority of this increased cost will have to be met by other agencies than the North Carolina Legislature.

(*h*) *Tulane University.*—In a proposed expansion of the entire school, the expansion for the department of tropical medical and public health of about 13,500 square feet would cost approximately $275,000, and with this expansion the equipment would cost about $150,000. This would allow the school to take approximately 45 students instead of the 23 which they now have, with an increase in instructional cost of about $49,200.

(*i*) *Yale University.*—The school estimates that in addition to the new building the minimum they will require to meet their expansion goal will be $90,000. This will be needed for instructional costs, especially for biostatistics, medical nutrition, hospital and medical care, occupational medicine, epidemiology, housing, maternal and child health; and overhead costs. This would permit more effective work and expansion in enrollment of 30 to 40 percent.

E. RESIDENCE OF STUDENTS

Since approximately 68 percent of the students enrolled in the schools of public health come from States and countries other than the States in which the schools are located, and further, since the graduate students are being trained primarily for public service, it is felt that the Federal Government should share in the cost of this educational process. Table VIII shows the distribution of the current student load in these schools according to State or country of residence.

TABLE VIII

School	State residents	Residents of other States	Foreign nationals	Total students
California	50	17	7	74
Columbia	48	54	16	118
Harvard	30	45	28	103
Johns Hopkins	9	66	47	122
Michigan	22	34	15	71
Minnesota	36	32	16	84
North Carolina	20	44	15	79
Tulane	5	12	12	29
Yale	7	25	8	40
Total	227	329	164	720

EXHIBIT III. PROPOSED FORMULA FOR FEDERAL ASSISTANCE TO ACCREDITED SCHOOLS AND DEPARTMENTS OF PUBLIC HEALTH

(Developed at a meeting of the deans of the nine accredited schools of public health in the continental United States during January 1949)

(1) Determine the basic cost of operating the accredited program of the schools of public health, excluding funds obtained from other Federal grants and so-called project research funds.

(2) The Government to make a block grant amounting to one-half of the amount determined under paragraph (1), but not to exceed $250,000 per annum for each school.

(3) Grants per student:

(*a*) The Government to pay to the school $1,200 for each graduate student up to a base line of enrollment to be determined from some type of average enrollment in previous years.

(*b*) $2,400 per graduate student above that base line of enrollment.

(4) In order to discourage the development of "wildcat" schools, the total of the block grant (par. 2), plus the per capita grant (par. 3), could not exceed the basic cost of operating the school (par. 1), so that the amount provided by the Federal Government would never exceed the amount (par. 1) already provided by the school.

As pointed out, the application of this formula will require (1) a careful survey and analysis of the operating costs of schools of public health, and (2) the development of various technical details to administer the program properly.

EXHIBIT IV. RESEARCH IN SCHOOLS OF PUBLIC HEALTH

Research in our schools of public health strikes at the heart of disease prevention, using methods all the way from basic scientific laboratory investigations to large-scale field experiments in disease control. These schools are attacking epidemic disease threats like typhus and poliomyelitis. They have many researches under way against devastating nervous diseases such as the sleeping sickness encephalitis and the crippling killer, multiple sclerosis.

The schools of public health are working on the great problems of the common cold and influenza. They are searching to find how immunity to many diseases can be developed within the human body. Venereal disease control is one of their major projects. They are now also pioneering in research on degenerative diseases such as heart disease, arteriosclerosis, diabetes, and cancer; they are seeking the basic information needed to control these important causes of human suffering.

Costs of medical care will go down as we learn how to build healthy minds and healthy bodies. Our schools of public health have undertaken mental health projects and studies of social factors affecting the health of the mind. These schools lead in developing the body-building science of nutrition; here research problems in human nutrition extend from the unborn infant, through the stages of childhood, all the way to old age. Indeed, work now under way in these schools on the problem of aging undoubtedly belongs in one of the most important of all research fields.

Our Government is counting on the schools of public health for research to guard against the hazards involved in atomic energy development. They are making investigations for our armed forces on such problems as the food, clothing, shelter, and health protection requirements which will make troops more effective in Arctic climates. They are tackling control of malaria, the chief disabling disease of our troops in the tropics, as well as many other problems of tropic disease which affect our troops and the welfare of many nations we count as friends.

Both industry and labor benefit by the studies of our schools of public health, such as those dealing with control of accidents, now the fourth leading cause of death, and of industrial hazards, such as the poisonings and contaminations which follow chemical and technological advances. The "iron lung" resulted from industrial health research in a school of public health, and a new device for resuscitation by electrical stimulation of the phrenic nerve is now being developed.

Finally, these schools are improving public health by many special studies, such as effective methods for getting health knowledge to all the people through our public schools and popular education; investigation of the social and economic problem of medical practice; evaluation of labor union health, public health nursing, and crippled children programs, and researches dealing with wide use of X-ray and other diagnostic methods and of great new weapons against disease such as penicillin and other antibiotics.

Any program adopted for the expansion of the schools of public health should include adequate provision for the continuation and expansion of their research activities.

Senator MURRAY. The evidence which we have been receiving, General, indicates that there is a great shortage of doctors and nurses and technical workers in the medical care field. And you say there is also a great shortage of trained men in the national health service.

Dr. SIMMONS. Yes, sir.

Senator MURRAY. Have you any idea about the number that would be required to fill the needs?

Dr. SIMMONS. This estimate, sir, in exhibit 1, page 3, "Number of full-time trained public health workers needed by the United States in 1960." On page 2 is the "Estimated number of full-time public health workers now active in the United States."

That fact sheet, sir, shows the national need for trained public health workers and provision of adequate facilities for advanced postgraduate training by schools of public health. And on page 2, under paragraph 3, it shows the estimated numbers of full-time public health workers now active in the United States. And on page 3, paragraph 4, is shown the number of full-time trained public health workers needed by the United States in 1960.

Then on page 4, paragraph 5, it shows what proportion of that total will require the type of training that is given in schools of public health.

Senator MURRAY. Doctor, a fear has been expressed by some witnesses that if the Government engages in a program of aid to these schools that there might be a tendency on the part of the Government to dictate the policies and decide the programs, and so forth. Do you believe there is any danger of that kind?

Dr. SIMMONS. I would deplore that very much if it were possible. But I have no fear of it. I think the people of this country can determine the policy of Government agencies if they are on the job.

Senator MURRAY. You have had considerable contact, I suppose, with Government agencies?

Dr. SIMMONS. Yes, sir, I have just finished 30 years in the Medical Corps of the Army.

Senator MURRAY. Have you found any attempt at any time to dictate to you how you should operate?

Dr. SIMMONS. No more than the normal dictation that belongs in a military job, sir.

I would like to add, sir, that this testimony of mine has the sponsorship of Dr. Wriston, the president of the Association of American Universities I telephoned him yesterday, and he has read it, and he gave me permission to say his organization sponsored it.

Senator MURRAY. Do your associates here on this panel this morning wish to make any comments?

Dr. SIMMONS. This is Dr. Anderson.

Senator MURRAY. Dr. Anderson?

Dr. ANDERSON. I would like to merely add one or two words to what

General Simmons has said. I speak not only as secretary of the association but as director of one of the State-supported schools.

As General Simmons has said, there are nine of these schools in the United States, five of them privately supported and four of them supported by States.

The situation with respect to all of them, as he has said, is rather precarious from the financial standpoint, in that they are all operating either on a deficit or upon a very narrow margin.

In the case of the private schools it means a deficit in terms of the using of their endowment. In the terms of the State schools it seems we are having to turn to the taxpayers of those four States asking them to carry the burden of these four schools which are serving the Nation.

For example, in the case of Minnesota—and I can give you the details only for that one school, but the others are very comparable—we are at the present time having students from 16 foreign countries and from 13 different States of the Union, and yet the taxpayers of the one State are being assessed the cost of operating that school. It is our feeling that the only fair thing is a distribution of this cost among the several States, and that the only way that that cost can be properly distributed is through some form of Federal aid.

I know the situation is the same as in the other States. Not that they have been unwilling to carry their burden. In the case of Minnesota the appropriations for the school has been going constantly up. It has, as a matter of fact, during the past 5 years doubled, and it is going to be higher during the coming fiscal year, the coming biennium, than it has been in the past. The same applies to the other State-supported schools.

We can, of course, go so far to the taxpayers of the several States until they feel, and they may logically feel, they are carrying an undue burden. We can do that without drawing upon our endowment which is very small in the case of the State-supported schools. The private schools of course cannot do that. They have no taxpayer group to which they can go to carry off the deficit, and they are in the position of having to use up their endowment, which means that they can operate only so long before the endowment is gone.

It is our feeling therefore that there is a critical need for some assistance.

Now General Simmons has already pointed out to you the fact that we are going to need considerable sums for further expansion over and above the problem of merely operating as we are at the moment. There is this problem of expansion.

It is true that as of this moment there are occasional places for further students in the schools. We have not been in the position of turning away a student. But in terms of any considerable expansion it would not be possible with our present staff at the school, with our present physical facilities.

If you were to visit the several schools and were to walk through them, you would see a very severe overcrowding, operating under conditions which are not best for the highest quality of professional training. If you were to go through, as we are all going through at the present time, our problems of trying to maintain staff, to find staff in a field in which there is a great shortage, and with the salary situation such as it is, you would realize that we cannot continue to operate indefinitely without some sort of assistance.

It is for that reason, sir, we would urge upon the Congress that the provisions as envisioned in these particular bills be made a matter of law.

Senator MURRAY. The conclusions in the statement that you have given us appear to me to be absolutely correct. I do not see how we can avoid the need of assisting these schools because they are an absolute necessity for the country, and without the Federal aid, as you say, it would be impossible for you to go on.

I understand that representatives of these public-health schools intend to sit in with the experts on our staff to try to help to work out the problem.

Mr. ANDERSON. We greatly appreciate that opportunity, sir.

Senator MURRAY. I think that is an excellent way to work out a bill that will not have any flaws in it. We are doing the same thing with reference to other phases of the national health problem.

Do you wish to comment, Dr. Hiscock?

Dr. HISCOCK. Mr. Chairman, just a word. As a representative of one of the accredited schools of public health, I wish to support the statements made by our president, General Simmons, and our secretary, Dr. Anderson.

There is urgent need in all of these recognized schools for financial assistance in the programs of professional training in public health. The subject has been under discussion for quite a number of years, and I wish to emphasize that; otherwise it could not have gotten out such a statement which has been presented.

The students coming for graduate training at Yale, which must be individualized, as emphasized by other speakers, come from over 20 States, Alaska, Hawaii, and several foreign countries, and from Federal service, for example. That is a distribution factor of considerable significance.

Our financial resources at Yale are too limited for the great task. The size of our teaching staff should be increased, as well as an increase in quarters, because we are tremendously overcrowded for the number, and yet we are limiting the registration.

Furthermore, Mr. Chairman, as chairman of a committee of the Public Health Association on State and local health administration, and the boards and committees of voluntary health agencies, I am impressed daily by the importance of well-trained personnel in order to help make efficient these programs of our communities and of our States, and of the voluntary national and local agencies in heart disease, tuberculosis, cancer, occupational medicine, venereal-disease control, and mental hygiene. This trained personnel is basic to the operation on an efficient basis of those activities which are now in process or are in the developmental stages.

Today this shortage is acute and the need for training is urgent and essential for the people.

This matter is at the core of health conservation and will pay large dividends in human life and production.

The need is at a time of great opportunity to utilize the available knowledge we have, and at a time when there is a peak of public interest in these affairs, sir.

Thank you, sir.

Senator MURRAY. Thank you, gentlemen. We appreciate the very clear way in which you have presented this matter.

Dr. SIMMONS. Thank you, Senator Murray.

Senator MURRAY. Dean Carlyle Jacobsen of the State University of Iowa.

STATEMENT OF CARLYLE F. JACOBSEN, EXECUTIVE DEAN, DIVISION OF HEALTH SCIENCES AND SERVICES, STATE UNIVERSITY OF IOWA, REPRESENTING THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES AND THE NATIONAL ASSOCIATION OF STATE UNIVERSITIES

Mr. JACOBSEN. My name is Carlyle F. Jacobsen. I live in Iowa City, Iowa. I am the executive dean of the Division of Health Sciences and Services of the State University of Iowa, responsible for the educational and service programs of the colleges of medicine, dentistry, nursing, and pharmacy, and for the university general hospital and the psychopathic hospital, with a total capacity of 1,000 beds. I appear before you today not, however, as a representative of the State University of Iowa, but as a dean responsible for education in the health fields at one of the 34 tax-supported colleges of medicine and speaking at the invitations of the Association of American Medical Colleges and of the National Association of State Universities.

Your committee has indicated a desire to hear from profesional organizations engaged in education for the health professions. I deem it a privilege to appear before you and to present to you some of the problems confronting State-supported schools of medicine, dentistry, and the related professions.

Of the 71 medical colleges in this country which are members of the Association of American Medical Colleges, 34 receive virtually their entire operating budget from appropriations made by State legislatures or other tax-levying and appropriating agencies. Of the 5,500 physicians graduated from our medical schools in the year 1948, 1,890 or approximately 34 percent received their medical degrees from these tax-supported institutions.

In recent years the financing of higher education, and in particular the financing of education in the health professions, has become a major concern of every university president and board and, quite directly, of the public who demand increased health services. The fact that hearings on Federal aid to education for the health professions are being held before this legislative body is evidence to the acuteness of the financial problems for higher education.

NEED FOR FINANCIAL ASSISTANCE

The over-all needs for financial assistance in medicine, dentistry, public health, nursing, et cetera, have been and will be presented by the appropriate associations and by representatives of the Federal Government. I believe that I can contribute best to your understanding of these problems by citing the changes and retrenchments that have been found necessary at the State University of Iowa during the past 6 weeks in preparation of the budget for the next fiscal year, and by indicating to you some of the consequences of this retrenchment.

The Iowa Legislature, in keeping with many other legislative bodies throughout the midwestern area came far short of appropriating the funds necessary to meet the needs of the State University of Iowa, including those of the colleges of medicine, dentistry, and nursing. During the war years, the staff of these colleges was seriously impaired. In 1946 the university undertook to rebuild its teaching staff. The progress made is rather closely reflected in the budgetary allocation for these colleges during the first three postwar periods.

In successive years from 1946, the budget of the college of medicine rose from $523,000 to $754,000 and to the present year at a figure of $910,000. In the college of dentistry, the picture is similar, from $126,000 in 1946 to $162,000, and this year, to $186,000. In order to remain within our appropriated moneys for this next biennium, it has been necessary to reduce the budget of the college of medicine to $853,000, or a reduction of slightly over 6 percent, and in the case of the college of dentistry, $169,000 or a reduction of approximately 9 percent.

Budget appropriations

	1946–47	1947–48	1948–49	1949–50
Medicine	$523, 616	$754, 790	$910, 435	$853, 837
Dentistry	126, 542	162, 307	186, 816	169, 414

Let me translate these budgetary reductions into terms of teachers, who are the heart of a sound educational program. It has meant the deletion of the following necessary but as yet unfilled positions in the college of medicine: one professor, two associate professors, four assistant professors, and two instructors. In one instance, a seasoned and wise teacher will have to be replaced by a relatively young and inexperienced assistant professor. In our department of obstetrics, the staff has been reduced from five to three and is at a dangerously low level for a good educational program.

Deleted positions

	Medicine	Dentistry	Nursing
Professor	1	1	
Associate professor	2		
Assistant professor	4	2	2
Instructor	2	3	2

The most serious and regretted reduction may occur in our department of orthopedic surgery which for many years has been outstanding in its service to crippled children. The university now finds itself hard pressed for the necessary resources to appoint a man of distinction to the top position in this department.

This reduction in staff becomes the more tragic when one considers that enrollments in medicine and dentistry will be greater next year than at any time in the postwar years, and that the university is now under instruction from the people of Iowa, through its legislature, to increase its student body in medicine from 90 to 120 students in the freshman class, although adequate financial provision has not yet been made for the recruitment of additional staff and for needed laboratories and clinics.

I might add that next fall we are taking the first step of increasing the class from 90 to 98, even though we have not been able to expand our resources for doing that.

Senator MURRAY. That will mean quite a burden on the staff, then?

Mr. JACOBSEN. It means a considerable increase of teaching responsibility to the staff, which is already working fairly well toward the upper limit of its ability.

We are currently working with representatives of our legislative body in the effort to work out a plan that will give some relief there, but as of the present time this is the picture that we face.

Student enrollment

	1946-47	1947-48	1948-49	1949-50
Medicine	288	278	299	320
Dentistry	142	155	179	220

These enrollment figures demonstrate that the university has been endeavoring to train health personnel in these fields.

Percentagewise and in actual amount, the reduction of budgets in the Colleges of Medicine and Dentistry have been relatively small, and the net effects on the faculty and on the quality of education in the health professions will not be disastrous in the immediate year ahead. However, a continuation of this trend constitutes a serious and real threat to the future of medical, dental, and nursing education at the State University of Iowa.

The people of Iowa and their legislative representatives have demonstrated over the years by their financial support that they wish to have a good and sound program in dental, medical, and nursing eduction. They are proud of the steps they took 25 years ago in establishing a medical center at the University of Iowa, thereby pioneering a pattern that has been adapted to many other State universities. They wish to give adequate financial support to their schools and colleges.

However, the problem that confronts the tax-supported schools today is that of being in a highly competitive struggle for tax moneys with new and worthy welfare programs. This demand for other services has increased enormously in the past quarter century.

The trend of this competition can be clearly shown in the following summary:

1. From 1920 to 1933 the fraction of the tax revenue devoted to the State University of Iowa never fell below 5.33 percent.
2. From 1934 to 1948 the fraction never rose above 3.87 percent.
3. In 1947-48, the last year reported, the fraction stood at 2.67 percent.

That former sources of income to the tax-supported university are being diminished is clear. If the educational programs are to be maintained, new sources of support must be found.

If I may remark at this point, I would say that this was the matter which caused me yesterday to speak of the need for some provision in the bill that would assure continuing participation by the States in the support of their educational programs in the health profession, at least up to the level that they are operating on at the present time; and that it would be a tragedy if the Federal aid to medical education were merely to result in the substitution of Federal money for State support previously.

It is not unusual that the State universities operate under a plan whereby they cannot incur a deficit in their operation, and their only alternative if they do not have the money necessary to do the job is not to do the job at the level that is appropriate and which they would like to reach in their effort.

The problems of other State universities are not unlike those at the University of Iowa. Our University is not among the most favored of State institutions, but Iowa has been far from the least fortunate of State universities. Because of this fact, I have been requested by President Stoke of Louisiana State University to offer at this time a few comments on behalf of the National Association of State Universities. This association, composed of the State-supported universities of the country, meets but once each year. At the time of the last meeting, the association took no formal action on the matter of Federal aid to education in the health professions, since at that time the legislation under consideration today had not been presented to the Congress. I am requested by the secretary of this association to indicate, however, that much informal discussion took place concerning the financial problems of medical education, and that it was the consensus of these informal discussions that Federal assistance was needed and desirable if the quality of present-day education in the health professions was to be maintained.

Our attention has been focused on the needs for assistance to medical education, but may I point out that the need is not limited to the colleges of medicine. Medicine has been a favored field both in terms of institutional planning and in the support which it has received from private donors and foundations. Dentistry, public health, and nursing have often played the role of the neglected stepchild. It is my opinion that aid to education in the health professions should be planned on a broad, comprehensive, and continuing base with provision for including any one of the four major areas as soon as it is educationally sound to do so.

THE EXTENT OF AID REQUIRED

The amount needed for aid to medical education alone has been estimated to be as high as $20,000,000 and even $40,000,000. Sums of similar size will probably be needed in support of dentistry and nursing. Certainly in considering Federal aid, such long-term objectives should be kept clearly in mind. It is doubtful, however, whether such sums can be wisely used in the immediate year ahead. I believe the extent of support contemplated in S. 1679 and S. 1581 is conservative and can be wisely used by the educational institutions now.

The above-mentioned bills contemplate the use of a straight per capita payment to the educational institution. This formula has the virtue of simplicity and objectivity in administration. It is possible that a formula which involves support based on a block grant and a per capital allocation would more effectively achieve the aim of this legislation, since it would further strengthen the financially marginal schools.

I am thinking here particularly of State universities in that connection.

Senator MURRAY. What do you mean by "block grant"?

Mr. JACOBSEN. A provision whereby a sum of $100,000 or $150,000 might be granted to any educational institution without respect to the size of its student body, and then have a second factor operating: namely, a per capita allocation in addition to that block grant. That would be in a measure giving recognition that any medical school or dental and public health and nursing, that any school is performing a certain national service at its basic level, and this would be in recognition of that. And then a per capita grant in addition to that that would recognize the problems of the school with a larger enrollment in contrast to the school with the smaller enrollment.

A third factor which would recognize quality of instruction given has also been suggested.

It is my opinion that prompt financial assistance to education in the health professions is of first importance and that the matter of formula by which such allocation will be made can well be left for study by the review commissions which are provided for in the several bills mentioned above.

In planning financial aid to education in the health professions, the Congress should expect to maintain this aid for a continuing period. Few schools can afford to expand their faculties and physical resources unless they can be assured that assistance in the operation of these programs will be continued. Certainly a school which is already hard pressed to meet its current operating budget should properly hesitate to enter upon an expanded program unless firm and continuing financial support is assured.

CONSTRUCTION GRANTS

If the number of students enrolled in colleges of medicine, dentistry, nursing, and public health is to be materially increased, it can be done only through the expansion of present facilities or the construction of new schools. The principle of requiring matching funds by the educational institution and the Federal Government is a sound one in that it provides some control of hasty and ill-planned expansion. The requirement that matching take place on a dollar-for-dollar basis (or 50 percent) may be too high. Both operating and capital resources of educational institutions at the present time are seriously reduced. It is significant in this respect that a more liberal formula has been recommended in current legislation for aiding the States in the construction of hospital facilites under the so-called Hill, Taft, and Thomas bills. This current legislation extends the formula to provide up to two-thirds or even three-fourths of the funds needed in hospital construction. It is my opinion that the expansion of teaching resources in the health professions can be more readily achieved through a reduction of the matching requirement to 33-percent instead of the proposed 50-percent basis.

In summarizing the need for financial assistance to the schools, I would give the following order of emphasis:

1. Prompt financial assistance at this time in order to sustain and maintain present level of education in the health professions.
2. Provision of capital and operating funds for expansion of present education resources, both staff and educational plant.
3. Assurance of continuing support so as to underwrite the costs of the expanded program.

Now may I comment on certain administrative provisions of the proposed Senate bill 1679?

The experiences of educational institutions during the war and in certain of the postwar research programs has caused their faculties and presidents to have grave doubts about the wisdom of accepting Federal aid to higher education. However, in view of the assistance that is now being given in the fields of agricultural education, research in the physical sciences and the very broad programs in aid to teching and research in the health professions now administered through the United States Public Health Service, it is clear that the question is not whether the Government shall give financial assistance in higher education, but rather, how shall such assistance be administered and how much shall it be.

For the past 3 years it has been my privilege to participate as a citizen in the work of the advisory mental health council as a member of study committees, and in the past year as a member of the National Advisory Mental Health Council. I firmly believe that the Congress, when it established the several health councils and institutes such as the Mental Health Council, the Heart Institute, and oldest of all, the Cancer Institute, has provided a satisfactory operating pattern that draws upon the technical resources of the experts in the field to advise and counsel with the governmental administrators responsible for the operation of the program. The councils mentioned include in their membership representatives from the specialized and technical areas and, wisely, representatives of the public at large.

The proposal to establish a National Council on Education for the Health Profession can, under appropriate conditions, adequately safeguard the planning and administration of Federal aid in the health professions. Present provisions of section 102 should be strengthened by defining more clearly the responsibility and authority of the proposed council. The present formulation gives no specific expression of the advisory responsibility of this council.

May I offer one further suggestion with respect to administrative provisions of this bill. It is important that provision be made for the appointment of civil-service employees for the administration of the Federal-aid program. These officers should be chosen with due reference to their broad knowledge of the educational problems in the field of health professions.

Such top administrative officers should have competent technical assistants for the major areas of the program. In order to attract to such positions experienced persons from the health professions, it will be necessary to create civil-service appointments in the P–8 and P–9 categories. Provision for such positions have been made in title II, section 406, of H. R. 4313 and S. 1679. If the provisions of this section are interpreted to apply to title I also, the need will have been met. If, however, section 406 applies only to title II, then a similar enabling provision should be inserted in title I.

In closing, may I comment on the scholarship plan.

The primary need now is for financial assistance to the medical, dental, and related schools in support of their presently impaired operating budgets. The need for the scholarship plan is a secondary one as of this moment. Indeed, there is no use in giving a scholarship unless there is a school to which you can send the student.

I would like to qualify that and point out that comment would apply particularly in the case of medical and dental schools where the number of students now seeking admission are quite adequate. I think our problems in the field of nursing, and perhaps in public health, are in a little different category where they could now use a measure of assistance that is in my opinion not needed in the case of medicine and dentistry as of this time.

With the expiration of the provisions of the GI bill and the using up of entitlements by present students, it appears quite probable that increasing numbers of students will find it impossible to enter upon the expensive courses of study in medicine, dentistry, public health, and to a lesser extent, nursing.

If a young doctor has found it necessary to borrow from $5,000 to $8,000 to complete his education, he faces a severe and almost hopeless hardship at the outset of his professional career. I find myself, therefore, in sympathy with the scholarship and loan provisions of these bills. It is my opinion that scholarship aid will be required in the years ahead if the number and proficiency of persons trained in the health professions is to be maintained and increased.

I thank you for the opportunity of presenting this statement.

Senator MURRAY. Thank you very much for your statement.

You understand that representatives from these schools will be meeting with our staff and helping us?

Mr. JACOBSEN. Yes, sir.

Senator MURRAY. We will be very glad to have your cooperation there, too.

Mr. JACOBSEN. Thank you.

Senator MURRAY. The next witness is Dean R. W. Bunting.

STATEMENT OF RUSSELL WILFORD BUNTING, DEAN, SCHOOL OF DENTISTRY, UNIVERSITY OF MICHIGAN

Mr. BUNTING. I hope, gentlemen, that anything I shall say here today will be recognized as only my own personal opinion, and that I am not representing American dentistry or American dental teachers. I just learned as I came into town today that the dental teachers the latter part of this month will consider this whole question as to how far dentistry wishes to participate.

I had not known there was a reluctance that seems to be there. I do not think it is reluctance; I think they have not made up their minds yet; so no one can speak for dentistry at the present time, much less myself.

Senator MURRAY. I am sure your own opinions will be very helpful to us, Dean. You are recognized as having a broad understanding of this problem.

Mr. Bunting. I am appearing in the interest of dental education. My qualifications to speak are based on 40 years of teaching and research in the School of Dentistry of the University of Michigan and 12 years as dean and chief admissions officer in the same institution. I am a former consultant of the United States Public Health Service. I am deeply interested in the future of dental education and practice as they are related to the newer concepts of public health service.

First I will take up the shortages in professional health-service personnel.

It is generally agreed that there is a shortage in medical, dental, and public health personnel in this country, and that any plan to afford more adequate health service to the people will require more physicians, dentists, and public health workers. Considerable study has been given to ways of meeting that shortage.

Bill S. 1453 and the so-called omnibus bill, S. 1679, offer assistance to schools for operation and enlargement and aid to students in the form of scholarships. The bill under consideration, S. 1581, offers but minimum aid to medical schools and does not include the other health professions.

The burden of increasing the number of practitioners in the health-service professions definitely falls upon the schools which train them. This burden is threefold: First, the provision of an adequate plan and facilities for its operation; second, an adequate teaching staff, involving a salary budget that will induce and hold well-trained teachers to remain for a long period of years; and, third, an adequate pool of applicants from which a well-selected student body may be chosen.

Schools undoubtedly need financial assistance from some source.

At the present time it is undoubtedly true that there are many professional schools that are hard pressed for funds to meet their existing operational costs and to maintain their faculties. In many respects their educational functions are hampered and the quality of their teaching suffers from lack of adequate financial support. For them the enlargement of their student body, without a resultant loss of teaching efficiency and quality, is quite impossible. Therefore, any general increase in the enrollment must be predicated upon some form of assistance to professional schools, especially those which do not now have adequate financial status. Major appropriations must be forthcoming from some source to enable them to build their teaching staffs to the maximum utilization of their present building facilities and further expansion will entail constructional enlargement.

Unquestionably, for some health services new schools must be built to augment those now in operation, involving buildings, operational costs, and faculty, which will require still larger financial resources.

In a consideration of any over-all assistance to professional schools, it is exceedingly difficult to arrive at any basis of costs of education in the various schools. Most of them are parts of universities in which they share in the general university budget, so that the actual cost of such professional units cannot be accurately determined. Recently, a study of dental education was made at the University of Michigan to determine the cost per student, and after deducting the tuition and clinical income, the unit cost was estimated at $1,123. Other schools have submitted estimates that are somewhat higher and some lower, but since the Michigan budget is one of the highest among all dental schools, it may be presumed that this figure is a fair estimate of the cost of dental education in the better-supported schools.

PROPOSED FEDERAL AID

Bill S. 1679 provides for aid to dental schools on the basis of $250 per present student enrollment and $1,300 for additional students admitted. Such aid unquestionably would enable dental schools to strengthen their faculties, and to increase their enrollment to the maximum of their building facilities. It would also provide necessary equipment and teaching facilities which most of them need.

The inclusion of $150 and $800 stipends for students of dental hygiene is also highly desirable. These ancillary aids to the dental profession are very important to the expansion of dental-health service and should not be left out of any planning for the dental needs of the public. They are fast becoming as essential to dentistry as is the nurse to medicine.

NEED FOR SCHOLARSHIPS

However great the need may be for financial aid to build new schools and to provide adequate support for existing schools, in order that they may improve their teaching and enlarge their student capacity, I especially wish to stress the third element of professional education, namely, the source and character of student enrollment. It will profit us little if we enlarge our teaching facilities only to find that there are not enough well-qualified applicants to fill the maximum enrollment of classes.

In medicine, there is now so large a pool of young men and women who are seeking admission that there is little danger of a dearth of applicants to fill all of the schools for some time to come. In dentistry, however, and in other health-service professions, the situation in the near future may be very different especially if there should be a general economic recession in this country.

Senator MURRAY. Why would that affect the situation, an economic recession?

Mr. BUNTING. May I continue, and I think it will become clear.

Senator MURRAY. All right.

Mr. BUNTING. It is a question of cost to the student.

As an admission officer of a dental school, I am deeply concerned over the difficulties that may arise in filling our classes in dentistry after the present veterans' educational benefits have ceased. For 10 years previous to the close of the war, there were not enough applicants to fill our classes and because there was plenty of room poorly prepared students were admitted, many of whom failed. One of the reasons for the small number of applicants was the high cost of dental education and the expensive instruments and equipment that are required, the highest I believe of any professional program.

It was out of the reach of many young men who would have liked to study and practice dentistry. Only those could enter who had the necessary funds, and they were not always the best qualified.

Since the war great numbers have been seeking admission to dental schools, most of whom are veterans and are afforded the veterans' educational assistance. At present, the number of applicants is much larger than can be accepted in all dental schools, which makes it possible to choose the better-qualified candidates. This has raised the standard of dental education and practice. When the GI benefits cease, there is real reason to believe that the potential source of dental students will greatly diminish and may approach the prewar level. It is in view of this situation that dentistry might welcome Federal aid to students to help them undertake a highly expensive and otherwise prohibitive form of training.

FEDERAL PROPOSALS FOR STATE SCHOLARSHIPS

Bill S. 1679 provides for scholarships in all professional schools consisting of tuition, books, fees, and equipment, and in addition maintenance, not to exceed $125 to $175 per month. At the termination of the professional training, the student has the option of repaying the full amount of the scholarship funds received or of serving in State or Federal health services, 1 year for each 2 years of educational support.

I believe one other bill has been proposed which mentions 5 years of service, but none of the others have. The more recent ones have 1 year or 2 years of service.

Much can be said in favor of this plan which would enable many young men to enter the health professions, who, because of financial status, could not otherwise do so.

This applies to all medicine, dentistry, public health, and nursing, and so on.

It would also afford a constant source of personnel for the health services in which there is so great a need at the present time. I mean the larger national public health service, the Army and Navy, the Veterans' Administration, and so on, where they need personnel.

But I wish to raise an objection. I do, however, seriously question the wisdom of providing students with the entire cost of a professional education and support for themselves and their families during their period of study. This plan savors too much of buying professional students. The recipients would receive from the Government $8,000 to $12,000, and they would be afforded a training that would be of great social and economic value throughout their lives to them. Such privileges cannot be offered to young men in other walks of life. I ask you, gentlemen, is this not class legislation?

I believe that it is unfair not only to those who cannot participate in this bonanza, but also to those who do, to say nothing of the taxpayer who foots the bill. It would give to those that are selected a false sense of values. It would deprive them of the many disciplines of personal responsibility which are usually incurred in education and wihch have their uses in character building. It also would add an appreciable load to the tax roll that is not necessary to attain the desired ends.

SUGGESTED STATE SCHOLARSHIP PLAN

I suggest that the student bear a part of his education, a part that most of them could undertake. If the tuition and supplies were furnished at a cost of approximately $750 per year. That is $500 for tuition and $200 per year for supplies. There is a little leeway either way, but that is a fair average.

The total amount involved, over a 4-year to 6-year period, would be $3,000 to $4,500. The student would be expected to furnish his own living, and upon completion of his training would be required to spend 2 to 3 years in Government service or repay the loan as the bill provides. This plan would not pauperize him and would be a much more reasonable contribution to his future. This alternate plan would greatly reduce the total cost of such professional educational subsidy and would lighten the load on the taxpayers.

NUMBER OF SCHOLARSHIPS TO BE AWARDED

As far as I can see, there is in these bills no limitation of numbers of such scholarships to be awarded or their relationship to the number of nonscholarship students other than by the funds made available for this purpose.

Perhaps I am raising a question that will never occur.

I would recommend that the number of scholarships granted in the several schools should not exceed 50 percent of the total enrollment in each class. This would safeguard the interests of those students seeking admission who are able and would prefer to pay the whole cost of their education, but they might not be able to get in if the subsidized came in and crowded them out. I do not speak for public health; that is another matter. I can see their problem is different, especially from what was said this morning. But in medicine and dentistry, with the present great demand for medical and dental education, I am certain that a large surplus of students would be able to support themselves if they could be relieved of their actual educational expense during their professional training.

The plan which I have outlined would make it possible for most students who earnestly desire to enter the health professions to do so without imposing undue indebtedness upon them. It would give them a self-reliance and a consciousness of personal responsibility. It would also lessen any criticism that might come from aspirants in other fields of endeavor and from those who might oppose these bills on the basis of cost. This would also furnish a constant source of graduates who would be available for the public health services.

I realize that in what I have said I may appear to be blowing hot and cold. I am deeply concerned over the need for scholarships, especially for students of dentistry. The entire future of dental health service depends upon some such support for qualified students who are financially unable to meet the high costs of dental education. It is, in my opinion, the most critical need at the present time. But I am not in favor of depriving the student of his rightful responsibilities or the benefits of a reasonable contribution on his part for an education that is of so much value to him. I hope that some equitable basis of scholastic support may be adopted for the students of dentistry.

Senator MURRAY. Thank you for your observations, Dean. I think they should be given very careful consideration in working out this legislation.

Mr. BUNTING. Thank you.

Senator MURRAY. The next witness is George Bugbee, executive director of the American Hospital Association.

STATEMENT OF GEORGE BUGBEE, EXECUTIVE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Mr. BUGBEE. Mr. Chairman and members of the committee, I appear before you today to testify in regard to legislation before this committee recommending grants and scholarships for the education of medical, dental, dental hygiene, public health, nursing, and sanitary engineering workers. The purpose of these bills is to strengthen and expand the training of health personnel.

Hospitals participate in the training of practically all workers in the health field. Medical students in their last 2 years receive much of their education within the hospital. Postgraduate medical education is to a substantial degree carried on within the hospital. This same situation applies to an even greater degree in the education of nurses. By far the majority of schools for nurses are operated by hospitals and such schools graduate the major portion of nurses.

We would judge in reading the legislation before you that there is no provision for the training of many health workers needed within the hospitals. We refer particularly to dieticians, laboratory and X-ray technicians, nurse anesthetists, physical therapists, medical social workers, and medical-record librarians, occupational therapists, and hospital administrators. Without statistical support we nonetheless give our impression that the deficit in the personnel among groups mentioned above is, in some instances, more acute than the deficit of physicians and nurses. Further, training in these specialties bears very importantly on the demand placed upon the medical and nursing profession. We believe that this legislation, if enacted, should provide for the training of these other health workers.

The American Hospital Association through its official bodies has not had opportunity to express opinion on the specific legislation before you. The board of trustees, governing board of our association, on February 2, 1949, in considering the question of the need for additional health personnel voted as follows:

That the American Hospital Association urges educational institutions now training workers in the health field to do everything possible to meet the present need for physicians, nurses, and other health personnel; further, that the association support the principle of Federal aid for research, education, and training of health personnel in accordance with the need for such training in excess of that which can be met by present training facilities or resources, so long as the need exists. There appears to be a definite need for support now for at least some medical schools and for an increase in educational capacity viewed country-wide.

The board of trustees at the same February meeting of this year, in considering the likelihood that legislation would be offered to the Federal Congress to increase the number of graduate nurses, voted that such legislation, if introduced, should be considered by the association on the basis of the following factors:

(*a*) The aim of such legislation should be to provide more nurses and the legislation should be drafted to accomplish that aim;

(*b*) Such legislation should provide specifically for recruitment of more nurses;

(*c*) If benefits are to be provided to schools of nursing, the only limitation should be to schools licensed by the proper authorities of each State;

(*d*) The legislation should provide that grants be available to all schools of nursing, both governmental and nonprofit;

(*e*) Provision should be made for allocation of funds geographically on a basis related to the need for nurses; and

(*f*) In the administration and development of regulations, the administrator of the act should be required to secure the approval of an advisory council with adequate representation of educators from the hospital, medical, and nursing professions.

Federal legislation granting large sums to strengthen and expand nursing education sharpens the present discussion of the changes to be made in the education of nursing personnel; changes which must come if there are to be larger numbers of nursing workers with educational qualifications for service to be rendered the sick. There is still much controversy as to these changes which impose a special problem for this committee as it considers Federal aid.

On the basis of the above-enunciated principles we have the following general comment to make in regard to title I, Education of Health Personnel, in S. 1679: There are two stated over-all purposes for this legislation—one involves strengthening the schools; the other is aimed at expanding the education of health personnel. It is rather difficult to determine the effect of certain provisions of this legislation in relationship to these two purposes.

VARIETY OF PROBLEMS REQUIRES DIFFERENT APPROACH

We believe that applying many of the provisions to the education of all types of health personnel mentioned in the bill leads to a cumbersome approach to the particular needs for training specific types of personnel. The problems are quite different for different types of personnel. For example, medical schools are not short of qualified applicants, but rather there is a question of supporting present medical education and providing expanded facilities. On the other hand, while there is need for strengthening and improving nursing education, the problem is a shortage of applicants to fill present schools and improvement in the quality of teaching. Further, for many of the health workers considered in this legislation the problem is primarily a shortage of adequate funds to employ workers after education.

NURSING EDUCATION

Section 372 (b) (3) outlines aid for nursing education, providing grants for degree nursing and for basic training leading to a diploma as a professional nurse. There is no clear statement in the legislation defining degree and diploma schools. This should be remedied by a definition within the act. There are presently a very limited number of degree schools of nursing within the country and there are several types of degree schools. There is a general feeling that a greater number of nurses need the type of training provided in degree schools. The grant of $200 for each student enrolled and of $1,200 for each additional student enrolled is generous if the average period of service for degree nurses is compared with the period of service for physicians. Further, it is not clear whether, under the act, a school which installs a degree course would be entitled to consider all enrollment as additional enrollment when changing from a diploma to a degree course.

Most of the nurses in this country are presently being educated in hospital schools offering only diploma courses. The payment of $200, $150, and $50 for each student in the 3 years of training, and the requirement that the hospital give tuition, books, and other facilities without charge, substitutes the Federal payment for amounts which, in some schools, now are being paid by students. This provision would reduce the funds available for certain good diploma schools where tuition and other charges mentioned in the bill are now in excess of $400. The council on professional practice of the American Hospital Association, in considering this portion of the legislation, recommended that the payment be made to each school for the account of the student without requiring hospitals to change their present practices with regard to tuition, books, and other facilities.

S. 1679, section 372 (e), defines the schools which are entitled to grants. A similar clause defines schools which are eligible for attendance by those being granted scholarships. Schools for certain types of health personnel which would be aided under the suggested legislation do not have approval by any, public body. However, schools of nursing are licensed by the States. As you will notice, the association believes that any school so licensed should be entitled to grants and scholarships, and that grants and scholarships should be limited to such schools.

DANGER OF ELIMINATING NURSING SCHOOLS

To place approval in the National Council on Education for Health Professions might easily permit that council to eliminate certain of the poorer schools. The American Hospital Association is in favor of strengthening nurse education. We are not in favor of eliminating schools which are now meeting local needs to the best of the ability of the area. We believe that many of the poorer schools are in the poorer areas of the country which are very short of graduate nurses. These are the areas which need better schools and more educational capacity.

The provisions in this legislation for scholarships seem very generous, and we question the wisdom of the investment of funds as suggested. The first section of this legislation, aimed at aid to schools, could accomplish the aims of the legislation for strengthening and expanding education of health personnel. Further, it would appear that the monthly allowance to those holding scholarships is extravagant for some of the health personnel suggested for such grants.

If scholarship aid is included, it would seem that provision should be made in section 377 for allotting scholarships geographically in proportion to need.

SCHOOLS OF PRACTICAL NURSING LIMITED IMPROPERLY

Title I, section B, of S. 1679 would provide funds only to schools for practical nurses which are under public supervision. The American Hospital Association does not agree to limiting the grants to schools under such supervision. Many hospitals can and should operate schools for practical nurses, and it should be possible to aid such schools.

The Advisory Council called for under section 4 (a) (9) does not make provision for a practical nurse. Since this is training in that area, we would assume that a practical nurse should be included in Council membership.

The over-all appropriation recommended for practical-nurse education is very generous; further, section 5 (b) (a) grants an unnecessary sum for administration. We believe the States should provide their own administrative money and that the total sum of $300,000 is not needed for Federal administration.

Further, we believe that the States should match Federal grants with equal sums and that this section of the act should provide a definite allocation to each State without allowing discretion for the distribution of funds on the basis of use by given States.

We commend the legislation before you for its over-all aims. We agree that there is need for greater numbers of trained health personnel. We do believe that your committee will find that this legislation requires careful study and revision before there is full assurance that it will accomplish most effectively and efficiently its over-all purposes.

Senator MURRAY. Thank you, Doctor, I fully agree with your last observation. There are a lot of technical problems involved in this thing, and we have to rely largely upon the advice of experts such as have been testifying here this morning. But I hope we will be able to work out a program that will be effective.

Mr. BUGBEE. I hope so.

Senator MURRAY. Thank you, sir.

That concludes the testimony this morning, and we will recess until tomorrow morning at 10 o'clock.

(Whereupon, at 11:45 a. m., the subcommittee adjourned, to reconvene at 10 a. m., Wednesday, June 8, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

WEDNESDAY, JUNE 8, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m. in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senator Murray.

Senator Murray. The hearing will come to order.

The first witness this morning is Mrs. Eugenia K. Spalding, member of board of directors, National League of Nursing Education, on behalf of American Nurses Association and National League of Nursing Education. Will Mrs. Spalding take the stand please?

STATEMENT OF MRS. EUGENIA K. SPALDING, MEMBER, BOARD OF DIRECTORS, NATIONAL LEAGUE OF NURSING EDUCATION, ON BEHALF OF AMERICAN NURSES ASSOCIATION AND NATIONAL LEAGUE OF NURSING EDUCATION

Mrs. Spalding. Mr. Chairman, in addition to being a member of the board of directors of the National League of Nursing Education, I am also a member of the special committee of the American Nurses Association on Federal legislation, and chairman of the committee of the National League of Nursing Education on Federal legislation.

I would like to bring to the table with me Miss Blanche Pfefferkorn who is the director of the division or department of studies, National League of Nursing Education.

And there are others in the room whom we would like to call upon for questions in their special fields.

Senator Murray. Very well. You can have any of them that you wish to sit with you or call upon them at any time during your testimony for additional statements.

Mrs. Spalding. I would like to especially call attention to Miss Edith M. Beattie who is chairman of the American Nurses Association special committee on Federal legislation.

I would also like to present Mrs. Olwen Davies who is assistant director in education for the Association of Public Health Nursing.

And if we have any questions concerning practical nurse education we would like to refer those to Miss Ella M. Thompson, president of the National Association of Practical Nurse Education.

Senator Murray. That will be fine. You may proceed.

Mrs. Spalding. The American Nurses Association, which I am representing, is the national membership organization of graduate registered professional nurses in this country, having an enrolled membership of over 165,000.

It has a constituent association in each of the 48 States, the District of Columbia, Puerto Rico, and Hawaii. These constituent units are composed of approximately 500 district nurses' associations. The association was organized in 1896 and has been functioning actively ever since that date for the following purposes, to the end that the public may receive better nursing care:

> To promote the professional and educational advancement of nurses in every proper way; to elevate the standard of nursing education; to establish and maintain a code of ethics among nurses; * * * to disseminate information on the subject of nursing by publications in official periodicals or otherwise; to bring into communication with each other various nurses and associations * * * of nurses throughout the United States of America * * *.

The testimony which I submit relates solely and entirely to title I of S. 1679. It is the result of the deliberations of the six national nursing organizations over a period of nearly 2 years. The names of these organizations are American Nurses Association, National League of Nursing Education, National Organization for Public Health Nursing, Association of Collegiate Schools of Nursing, American Association of Industrial Nurses, National Association of Colored Graduate Nurses.

During 1947 a statement of objectives concerning Federal aid to nursing education was drafted and approved by the national professional nursing organizations. These objectives have been the platform of professional nursing with respect to Federal aid for nursing education. A summary of the objectives is attached as exhibit I.

It is our conviction that financial aid is needed for nursing education in order to provide both the quantity and quality of nursing service needed to maintain and to improve the Nation's health. This conviction is held irrespective of the form of health legislation that may be enacted.

First, we would like to point out that the so-called shortage of professional nurses is not due to a decrease in the number of available nurses but due to an expansion of the fields needing nursing service. Actually there were more professional nurses employed in 1948 than ever before. In hospitals and schools of nursing there were 230,059 employed in 1948 as against 149,407 in 1944. This increase was evident not in one but in all types of positions. Teaching and supervising personnel had increased by 3,095 or 14 percent; head nurses by 5,858 or 25 percent; administrative personnel by 2,912 or 44 percent; and full-time general staff nurses from 56,766 to 104,041 or 83 percent.

Another significant figure in the hospital field is the increase in general staff nurses in institutions conducting professional nursing schools. Fifty-four thousand five hundred of these nurses were reported on January 1, 1949; the largest number in prewar years was 29,100; during the war it dropped to 18,000.

In the public-health field the number of employed nurses has also increased. In 1948, 22,600 public health nurses were employed; in 1944, 19,800. In industrial nursing the number employed in 1948 was approximately 10,000, compared with 9,400 the year previous.

One other set of figures that indicates the extent to which professional nursing has grown in the last two decades is the ratio of professional nurses (graduates and students) to population. In 1930 there was one nurse per 416 persons; in 1946 there was one nurse to every 316 persons.

UNFILLED NEEDS IN NURSING

But still there are not sufficient professional nurses. The American Nurses' Association professional counseling and placement service reported that 5,169 positions were registered with it during 1948 and of these positions, it filled 2,050 or 40 percent. All types of positions were included in those registered—2,424 included various kinds of institutional positions, and of this number 855 or 35 percent were filled. In the nursing education group only 20 percent of the positions were filled. While inability on the part of any placement service to fill positions may be due to lack of applicants both in number and qualifications, it may also be due to other causes. Among such possible causes are poor personnel practices of the employer, family responsibilities, and other factors which make it impossible or undesirable for applicants to go to localities where vacancies exist.

Figures from the nurse counseling and placement office, New York State Employment Service, also show a relatively small proportion of positions filled. That office filled one-third of the institutional positions (staff, teaching, and supervisory) registered with it and approximately one-half of the positions in the public-health nursing field.

A large university operating a placement bureau reported that for 323 positions as teachers and supervisors in schools of nursing and hospital it was unable to fill 209 or 65 percent; and of 158 public health positions (including staff, supervisors, administrators, and teachers) it was unable to fill 82 or 52 percent.

The Division of Nursing of the Public Health Service has made State-wide studies of nursing needs and nursing resources in different areas of the country in the last several years. Every study made showed there were not enough professional nurses.

In one large Eastern State the available number of professional nurses was 45,000, whereas at least 55,000 were needed. In two Southern States the needs for professional nurses exceeded supply by 1,500 and 2,500 respectively. A similar situation existed in a far Western State, the available number of professional nurses being 3,350 and the number needed 4,600.

The need for professional nurses, both in numbers and qualifications, is further indicated by the following facts. In 1948 there were 1,050 counties without any public health nursing service in the United States. Psychiatric hospitals have never had the number of professional nurses they need to give their patients the proper care. In 1948 there was 1 professional nurse to every 75 patients, and included in that ratio are administrators, supervisors, head nurses, and general-staff nurses. As a matter of fact, if only general-staff nurses are considered, the ratio is 1 professional nurse to every 245 patients, a shockingly low provision for professional nursing care. Even though nurses are the largest single group of health workers in the Nation there are not enough.

WHY THERE ARE NOT ENOUGH NURSES

The question might well be asked, "Why with the large and growing army of professional nurses is there the wide gap between supply of nurses and need for nurses?" At the risk of citing information which is already well known to this body we list the following factors:

1. Expansion of group hospitalization resulting in an increasing number of persons enjoying hospital services.
2. Expansion of hospital facilities. Each time a hospital is enlarged or a new one is built an increase in the hospital personnel follows. Of this personnel, nurses constitute a considerable number.
3. Increase in the number of health agencies employing public-health nurses. In 1948 there were 326 more such agencies than in 1947.
4. New developments in medical science and practice requiring expanding and new nursing services.
5. Expansion of the Veterans' Administration and Army and Navy Nurse Corps in connection with national defense.
6. Increasing number of persons in need of medical treatment and nursing care due to the increased life span and the complex conditions of modern living.
7. International health obligations. War and the aftermath of war have created vast problems of health and rehabilitation in Europe and Asia. People in those countries are looking to the United States for medical and nursing services in order to rebuild the minimum conditions for living a useful and healthy life.
8. Social and health legislation. At least 16 bills have been introduced by the Eighty-first Congress that include provisions which require widely expanded nursing personnel for implementation. Each time a legislative measure is enacted for the purpose of improving the health of the Nation (and many such have been enacted since 1932), implicit in the enactment is the need for more nursing personnel.

NOT ONLY MORE BUT BETTER QUALIFIED NURSES NEEDED

While the chief emphasis of the data submitted thus far has been on quantity needs, substantial evidence exists to support equally pressing needs in quality.

In 1948 there were 22,600 nurses employed by public-health nursing agencies in this country. Approximately one-third only of these nurses were qualified in terms of public-health nursing education, leaving 15,000 who were inadequately prepared and had to do their jobs as best they could.

In the fields of hospital nursing and nursing education the qualifications of nurse personnel are no better than in public-health nursing. There were 50,000 administrators, teachers, supervisors, and head nurses in hospitals and basic schools of nursing in 1948. Probably at least 30,000 of that number had no special educational background for their highly specialized functions.

I would like to say here that the need for administrators and teachers in schools of nursing was very serious before the war, became more serious during the war, and now is even more serious than it was at that time.

To get nurses in the field with the specialized preparation needed for their specialized functions, it becomes a high point of strategy to have a sufficient corps of nurse educations, who are comparable to the teacher training group in general education. At the moment the number of such qualified personnel is woefully inadequate.

It may seem paradoxical while urging an increase in the number of nurses to press forward the need for an over-all improvement of the profession. For the protection of the public we cannot conscientiously advocate the recruitment and training of large numbers of students in schools of nursing unless we have an adequate number of well-qualified nurse administrators, supervisors, and teachers.

Report on need to the President's Commission on Higher Education: The report submitted to the President's Commission on Higher Education estimated that 400,000 nurses would be needed by 1950. These 400,000 were professional nurses, although the number of practical nurses employed was taken into consideration when the estimate was made.

With the expanding demands for the services of professional nurses the need for enlarging the trained practical nursing group is increasingly being stressed. Once any considerable number of practical nurses who have had a course of instruction and experience in an accredited practical nursing school is available that group will provide a valuable auxiliary nursing service to supplement the service of professional nurses. At present, however, there are only 13,300 trained practical nurses in this country.

In 1948 there were less than 300,000 active professional nurses. With an estimated need of 400,000 this leaves a gap of 100,000. As the number of trained practical nurses increases this gap should tend to disappear. Irrespective of whether we need 100,000 or 50,000 more professional nurses, the need is sufficiently great to rouse concern and action.

How many trained practical nurses can profitably be absorbed we do not know and cannot know until more of that group are available to set up experimental services in each different type of hospital. But certain it is that we need many more than we now have. A target should be set for producing at least 50,000 within the next 5 years.

Financial needs in university schools offering advanced training: The facts concerning nursing are these:

(1) The needs for nursing personnel in a comprehensive national health program have increased beyond the present national facilities for preparing such personnel.

(2) The needs for personnel include both professional and trained practical nurses.

The expanded training of personnel—both professional and practical—can only be accomplished by increasing the number of competent personnel responsible for such training. Unless this can be done, standards cannot be maintained, and the result will be a lowering of the quality of the nursing service of the Nation.

Competent personnel responsible for the training of nurses include those functioning in nursing service as well as nursing education. Parenthetically we submit that nursing is learned by experience and participation in actual nursing service situations. A good educational program presupposes a good nursing service situation where students learn to nurse, which in turn presupposes well-qualified persons directing and supervising nursing service. Such personnel include, in the nursing-service field, administrators, supervisors, head nurses, and clinical specialists, and, in the nursing-education field, administrators of training programs—basic and advanced and practical-nurse-training programs—teachers of the different curriculum subjects in each type of program and supervisors of practical-nurse training in vocational education on the National and State level. In addition to the personnel required for operation programs there are also needed workers trained in the techniques of research and experimentation.

To prepare the nursing personnel needed in all types of nursing schools, universities offering such preparation need financial aid. The extent to which they need this help is indicated by information secured recently from 16 representative universities providing advanced training in nursing.

Nine of the sixteen reported they needed additional faculty members either to improve their present programs or to admit more students or both.

Five stated they needed clinical-practice fields—a facility which is generally considered a highly expensive item in the advanced training program.

Five also stated they needed more classroom and laboratory space and one university referred to the cost of building construction.

Five stated specifically they could not admit more students with present facilities.

Seven of the sixteen universities reported that they could not secure their needed faculty and facilities because of lack of funds. Twelve of the sixteen universities listed programs which they are not now offering but which they should be offering. Seven stated they could not develop these programs because of lack of funds; six seemed to be tied up with finances in some instances, in others with lack of qualified personnel.

The programs named most often as additional ones that should be offered are those that require clinical-practice facilities—a highly expensive facility in an advanced-training program. Ten such programs were listed.

There are 62 universities offering advanced-training programs. Since the 16 universities from which the above information was secured include a representative group among such institutions, it is highly probable that their financial limitations either to improve their present programs or to train more students are repeated in the other 46.

At the present time a large proportion of the recently initiated advanced clinical programs which include field experience are financed almost entirely through sources outside the institutions.

The evidence indicated emphatically the need for financial aid to improve the now existing advanced training programs, to develop new programs, and to provide the funds esesntial for equipment and construction of new schools and the expansion of existing ones.

FINANCIAL NEEDS IN UNIVERSITY SCHOOLS OFFERING BASIC TRAINING

In this country there are 1,215 basic schools of nursing. Of this number less than 100, or 8 percent, are schools which are college or university controlled and offer training leading to a baccalaureate degree. These schools, of course, bear a large share of the responsibility for the eduaction of the future leaders of the nursing profession.

Recent information received from a representative group of these collegiate basic schools indicates that they, too, are in need of financial aid if they are to expand their student body.

For example, one school reports that it needs more faculty, classrooms, and laboratories and clinical practice fields, and also enlarged residence and library accommodations. Other schools report either need for increased faculty or one or more of such facilities as residence, library, classrooms, and laboratories and clinical practice fields. Almost uniformly the inability to secure faculty and facilities is explained by the lack of funds, rising cost of construction, and lack of qualified personnel.

At a 2-day conference of authorities on nursing education in December 1948 the urgency of expanding the facilities of university or collegiate basic schools and establishing new ones was constantly stressed. It was pointed out again and again that professional nursing cannot meet its responsibilities in a world where all people—not just a few—enjoy health care and health teaching unless the number of nurses who have had a broad training, both general educational and professional, as given in a collegiate school are steadily increased. Then there will be more of the better-qualified nurses to go into the homes to teach the tuberculosis patient health measures, to promote his recovery and protect his family and community from contracting the disease; then there will be more of the better-qualified nurses to play their roles in preventing mental illness and in caring for and helping the patients in the mental hospitals to recover. Then, too, there will be more nurses who appreciate what they can do in the rehabilitation movement which has made such strides since World War II. It takes knowledge, art, and patience to help the patient who has had a cerebral hemorrhage to learn to talk again; to help the man who has lost his sight to regain some peace and some security in his new shut-out physical world.

But collegiate or university schools of nursing can grow only if they have the necessary funds. It is difficult to secure figures on the per capita cost of nursing students to the university, partly because usually universities do not segregate the costs of students enrolled in the different programs and partly because nursing education costs are complicated by costs inherent in giving the student hospital experience. It is, however, a well-known fact that student fees in a university do not meet the actual cost of education. In 1947 student fees in universities and colleges met only 56 percent of their total educational expenditures. Approximately 30 percent of that 56 was provided by payments of the Federal Government to veterans. In 1940, student fees covered less than 40 percent of total educational expenditures of those institutions. Universities or colleges without financial aid are not likely to find themselves able to initiate basic training for nurses or to expand their programs in places where such programs exist.

HOSPITAL SCHOOLS OF NURSING

Of the 1,215 existing State-accredited schools of nursing, approximately 1,125 are hospital-operated and controlled schools.

The student enrollment in these schools ranges from the very small school with 5 students to the very large with 464 students. The size of hospitals operating schools varies all the way from a daily average census of 16 patients to a daily average of 2,926.

There are some excellent hospital schools of nursing; it is safe to say there are many more mediocre and poor hospital schools.

An excellent or very good hospital school may be a financial liability to the hospital. A mediocre or poor hospital school will in all probability be a financial asset to the institution. During the period 1944–45 the Public Health Service made cost analyses in about 45 hospital schools of nursing. The findings of that study showed that, in general, the fees paid by students plus the financial value of their service to the hospital more than offset the total cost to the hospital of training and maintaining the students.

In another study of nursing education costs, costs were studied in three hospital schools, all three of which were generally regarded as good schools.

In one of the three, the annual net contribution per student to the hospital was $41.81; in another, $81.35; and in the third, $241.40. The total net contribution by these schools to their respective hospitals for the year was $2,675, $10,251, and $21,146. These contributions, which took into account both the fees paid by students and the service they rendered in the process of learning nursing, were over and above any expense incurred by the hospitals in the conduct of their schools.

It is not intended to imply that all hospital schools are financial assets to their associated hospitals. Many factors affect costs. One important factor is the size of the school; another is the breadth of the program, particularly with reference to the inclusion of such experiences as psychiatric nursing, tuberculosis, and other specialized services, where we really need to expand.

Certainly for some years to come, pending the expansion of collegiate basic programs and an increase in facilities for training practical nurses, the hospital school must be looked to for providing most of the nursing personnel needed; in 1948, 34,268 professional nurses were graduated, and of that number 1,215 were graduated from collegiate schools and received their baccalaureate degrees.

It would seem urgent, therefore, at the present time to give deliberate and careful consideration to hospital schools in any broad national health program. Those schools that show promise should be given financial aid to improve and broaden their training, and conversely financial aid should be withheld from those that do not.

PRACTICAL NURSE TRAINING

No consideration was given in the "Objectives" to Federal aid for practical nurse training. Those are the objectives worked out in 1947 by the nursing profession concerning Federal aid.

In the meantime it has become evident that such aid is highly desirable, and the national nursing organizations are agreed that there is an immediate and urgent need to organize a large number of practical-nurse training schools under the auspices of vocational education. It is desired to point out, however, that there is no provision in S. 1679 for nurse direction of the practical-nurse program in the Office of Education of the Federal Security Agency. It is hoped, as the practical-nurse training program progresses, that (1) nurse direction of practical-nurse training will be provided in the Office of Education and (2) that the activities concerning practical nurse training will be coordinated with professional nursing education as administered by the Public Health Service.

On January 1, 1949, only 71 schools of practical nursing were in existence. During 1948, 3,000 students were admitted to 71 schools, and 1,600 graduated. Altogether, 13,300 practical nurses were reported to have been graduated from these schools.

It has already been stated that we should aim at producing 10,000 practical-nurse graduates annually for the next 5 years. To graduate this number, it would probably require the annual admission of at least 15,000, allowing for withdrawal during the training period. Every possible recruiting measure will certainly need to be devised to bring up the admissions from 3,000 to 15,000. Practical nurses, trained properly, furnish a valuable supplementary nursing group to professional nursing personnel, thus increasing and improving the nursing service of the country.

In this connection we would like to point that the net effect of page 36, line 14, through page 37, line 11, and page 41, lines 7 to 13, of S. 1679 would appear to restrict the benefits of private nonprofit institutions to a much narrower range than those available to public institutions. Until there is further clarification available, we are unable to comment. We are asking for clarification of this language.

Student financial assistance is needed to secure the number of candidates needed in nursing. This is particularly true of applicants to college or university schools, both those offering basic and those offering advanced training programs.

Fourteen of sixteen university schools offering basic training report that they could take more students. The expense to the student for the entire program, including tuition, fees, other expenses, and maintenance, in college- and university-controlled schools in 1946 ranged from something less than $1,000 in a State university to $3,135 in a private college; and it is a well-known fact that educational fees have risen since then. The school in which students paid $3,100 for a 4-year program in 1946 reported that the cost to a student for the program in 1948 was $4,625. It seems highly probable that more students would go to these schools were they financially able.

I would like to point out, too, that this refers to the whole program and not to the per year cost.

When a graduate nurse goes to a university to secure advanced training, she is giving up the opportunity to earn for the period, and at the same time she is incurring educational expenses. Both college fees and living expenses are now at their all-time high. Many graduate nurses cannot afford a full-time advanced training program, even though they are capable and eager to undertake it.

In the fall term of 1948 there were 11,600 students enrolled for advanced training programs; 4,700 of that number were full-time students; 6,900 were part-time. It is a likely assumption that all or at least the majority would have been taking a full-time program had they been able to give up earning during the time necessary for them to complete their university work.

CONSIDERATION OF S. 1679, TITLE I

At a meeting of representatives of the six national nursing organizations in April 1949, the principle of securing financial assistance for nursing education through a Federal act providing such assistance for all health professions was unanimously approved.

We note that representatives from other health and allied professions testifying before this committee, such as the American Council on Education and the president of the Association of Schools of Public Health and Dr. Bunting, of the dental profession, are in agreement with this.

There are, however, certain differences in the provision of title I, S. 1679, and the "Objectives" previously referred to. We submit to the Senate Committee on Labor and Public Welfare the most fundamental of these differences, which will inevitably affect the quality of the nursing service rendered to the Nation.

Title I, 1679, makes no provision for much-needed research and experimentation in nursing education and nursing service, in the hospital field or other institution fields, in public health.

Now that there is concerted national effort to increase the number of trained practical nurses, we need experimentation in the conditions under which they can most effectively work. We urgently need studies to find out the sound numerical relationship of professional and practical nurse personnel. Another important type of study needed is that concerned with basic and advanced curricula.

Title I, S. 1679, makes no provision for a commission on policies and regulations. The Surgeon General has full power to prescribe all regulations, after consulting with the National Council on Education for Health Professions. The Council appears to be merely advisory in character.

Attached to this testimony is a list of recommended amendments to title I, S. 1679. That appears in exhibit No. 2. I will not read these unless you desire, Mr. Chairman.

Senator MURRAY. No; the exhibits will appear in the record at the end of your statement. We will have access to them.

I was going to suggest that you who represent the nursing profession will be invited to sit in with the technical staff of the committee to help in wording the bill as it will be finally presented to the Senate.

Mrs. SPALDING. Thank you, Mr. Chairman. I am wondering if, in addition to the members of the committee who are here with me today, who assisted in the preparing of the testimony, we might bring in about two others who represent other areas at that time.

Senator MURRAY. Yes.

Mrs. SPALDING. Thank you very much.

The amendments will, it is believed, clarify certain provisions of the bill and assure their proper interpretation and in addition strengthen the administration of the act.

In addition we should also like to raise the question why page 16, line 9 of S. 1679 restricts eligibility for payments to schools within the continental United States, particularly when page 33, line 10, includes Alaska, Hawaii, Puerto Rico, and Virgin Islands within the benefits of the program for practical-nurse training.

In addition to these amendments we wish to bring before the committee certain questions relating to the provisions for financial aid to schools that provide basic training leading to a diploma in nursing. That is section 372 (b) (3) (B) of title I, S. 1679.

We realize, of course, such a provision would be difficult, if not impossible, to enforce in this particular area.

Senator MURRAY. I guess that is right.

Mrs. SPALDING. There is no provision which requires a graduate of a school offering basic training leading to a diploma to remain in practice for a specified period of time after graduation.

There is no provision which prevents a diploma student from withdrawing at any point in her training without obligation for the training made available to her without charge. Thirty-nine percent of the students in the class of 1947 and also in the class of 1948 withdrew before they completed their training. Since 1938 approximately 30 percent of the students withdrew from each class before graduation. This loss by student withdrawals would be costly to the Government.

There is no "bonus" for the hospital school which increases its student body nor is there a bonus to stimulate the hospital school to increase its enrollment. We question this plan, assuming that the list of schools of nursing approved by the Surgeon General for Federal aid will include only those schools which should expand their enrollment.

We raise the question whether it is the purpose of this clause, section 372 (b) (3) (B), to subsidize all students or whether a school may admit a student who wishes to pay her own tuition and other expenses and allow her to do so.

We question whether the present provision in section 372 (b) (3) (B) will (1) help to improve the nursing services of the country, and (2) provide the number of nurses necessary for the health services of the Nation by stimulating enrollment in those schools able to prepare well-qualified nurses and by holding nurses in active practice after graduation.

Finally we ask whether it would not be wiser to follow in general the same plan for the schools ocering basic training leading to a diploma in nursing as that provided for other schools and allot to these diploma schools $150 for each student enrolled in excess of its average past enrollment, at the same time permitting the school (1) to continue to charge for tuition and other items of expense, (2) to use the funds allotted under this section for added instructional costs and scholarship aid, the scholarship aid not to exceed 50 percent of the total allotment, and (3) to obligate the student for service proportionate to the period of time for which the aid was received.

In closing, may I express to you, Mr. Chairman and the committee, the appreciation of the nursing profession for the privilege of presenting this statement which is based upon the results of serious and realistic study of the present situation and of the provisions in the bill relative to nurse training, and its relationship to the training of personnel in the other health professions.

We also wish to express our willingness to assist your committee further in any way within our power to secure such Federal legislation that will help provide nurse training that will improve nursing service in all of its aspects.

We believe that title I of S. 1679 has many desirable features and with certain suggested changes would serve as a basis for Federal aid to all of the health profession.

Senator MURRAY. Thank you, Mrs. Spalding. You have made many recommendations that will be very helpful, I am sure, to the committee in working up the final bill, and by sitting in with our staff you can render them much more help.

Mrs. SPALDING. We will be glad to.

(The exhibits in connection with Mrs. Spalding's statement are as follows:)

EXHIBIT I. SUMMARY OF OBJECTIVES CONCERNING FEDERAL AID FOR PROFESSIONAL NURSING EDUCATION

Prepared by a Committee of the National League of Nursing Education, January 1948

1. Purposes of professional nursing education

(*a*) Provision of professional nursing personnel qualified to render a high quality of service in the curative, preventative, and health fields of nursing.

(*b*) Provision of administrative and instructional personnel for the broad training of professional nurses as described in (a).

2. Types of professional nursing education essential to fulfill the nursing needs of society

(*a*) Broad general education and experience, including social sciences and the physical and biological sciences with great emphasis on the humanities and nursing arts.

(*b*) Preparation of nurses for all types of community nursing service and for administrative and instructional responsibilities in conducting nursing education programs, basic and advanced.

In order to prepare nursing personnel as described in (a) and (b), instruction should be coordinated with general education, public and private.

3. The public's stake in nursing education

The public should assume some responsibility for the cost of nursing education, since the welfare of the public is affected by the quality and quantity of nursing service rendered.

4. Status of Federal aid to nursing education

A study made in 1947 revealed that the major portion of Federal funds available for nursing education has been granted for scholarships for graduate nurses with the exception of funds allotted to the United States Cadet Nurse Corps program and in connection with the Social Security Act.

5. Proposed purpose of Federal aid for nursing education

Improvement of professional nursing services through the improvement of programs of profession nursing education, basic and advanced.

6. Proposed uses of Federal aid for nursing education

(*a*) National studies to determine qualitative and quantitative nursing needs.

(*b*) Preparation of skilled nurses for general staff in hospitals and other community agencies and for private practice.

(*c*) Preparation of educational, administrative, and instructional personnel for nursing service in hospitals and other community agencies and for institutions offering basic and advanced nursing education.

(*d*) Provision of educational equipment.

(*e*) Temporary demonstrations, intensive courses and workshops in nursing education.

(*f*) Research in administration of program and publication of findings.

7. Types of instructions suggested to receive Federal funds

Both those that are publicly and those that are privately supported.

8. Types of nursing programs for which Federal aid should be sought

Basic and advanced professional nursing curricula, regardless of race, creed, or color of controlling institutions.

9. Federal aid for scholarships

For students in advanced nursing programs.

10. Suggested Federal agency for administration of funds

The Committee believes it is not within its province to name the Federal agency. It was the consensus, however, that such agency or organizational unit thereof should be one whose primary purpose is higher education.

11. Regulation and policy-forming group

A civilian commission to include members of the nursing profession: Approximately two-thirds of the commission should be professional nurses nominated by six professional nursing organizations participating in the national structure study.

Functions of the Commission (1) to serve as a regulation and policy forming body, (2) to act in an advisory capacity to the nursing and other technical personnel responsible for administering the funds.

12. Distribution of Federal funds for nursing education

Go directly to approved institutions from the Federal agency administering the Federal funds.

13. General principles concerning Federal aid to nursing education

(*a*) Must not result in direct Federal control of any nursing education program. Federal statute should state plainly the purposes for which funds are to be used and also that the only Federal interest is to see that the money granted is used for these purposes.

(*b*) Role of Federal aid secondary and supplementary to aid from private sources and States.

(*c*) Regulations and policies set up by proposed commission not to interfere with educational and nursing services experimentation in individual institutions.

Role of national nursing organizations

(*a*) Suggest policies to guide legislators in drafting Federal legislation for nursing education.

(*b*) Develop and publish nursing service and nursing education standards to guide in developing or checking regulations and in solving problems in the administration of Federal funds.

(*c*) Study and influence passage or defeat of Federal legislation for nursing education.

(*d*) Nominate members for commissions and advisory and technical committees for Federal nursing educationd programs.

(*e*) Keep their membership informed on matters pertaining to Federal legislation.

(*f*) Prepare testimony on Federal legislation concerning nursing education.

Role of State nursing organizations

(*a*) Point out local and State nursing educational needs and make suggestions to national nursing organizations concerning educational policies and standards.

(*b*) Keep membership informed on Federal legislation concerned with nursing education.

(*c*) Inform United States Senators and Congressmen representing their respective States of desirable and undesirable legislation for nursing education.

EXHIBIT II. RECOMMENDED CHANGES IN BILL S. 1679, TITLE I

Page 11, line 23 through page 12, line 3:

As stated in bill: "by giving financial assistance for the construction and equipment of new schools and the expansion of existing schools, with a view to providing opportunities for more qualified individuals to obtain such training regardless of their race, creed, color, or national origin."

Recommended change: Insert "sex" before "creed".

Reason for recommendation: In order that schools training men nurses might receive the benefits provided in the bill.

Page 13, lines 16–21:

As stated in bill: "(3) to each school of nursing (A) which provides basic or advanced training leading to a degree in nursing, $200 for each student enrolled for such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment;"

Recommended change: "(3) (A) to each university—or college—controlled school of nursing that provides basic or advanced training in nursing for which it grants a baccalaureate or higher degree, $200 for each student enrolled in such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment;"

Reason for recommendation: There are some hospital-controlled schools of nursing operating basic programs which have arrangements with colleges or universities, whereby the colleges or universities grant credit for the hospital school programs toward a degree, although the hospital school programs are not controlled by the colleges or universities. Such schools properly fall under the classification of (3) (B) page 13, line 21 to page 14, line 4, since the intent of (3) (A) would appear to be to provide financial assistance to schools of nursing controlled by universities and colleges. Universities and colleges offering basic or advanced training in nursing may grant degrees in nursing or other degrees on a baccalaureate or higher level; and all such training and degrees should be included in the coverage of the bill.

Page 16, line 1:

As stated in bill: "first semester".

Recommended change: Substitute "first regular term" for "first semester".

Reason for recommendation: All universities do not operate on the semestral plan.

Page 22, lines 14–17:

As stated in bill: "In order further to increase the number of persons adequately trained in the fields of medicine, dentistry, dental hygiene, nursing, public health, including hospital administration and sanitary engineering * * *"

Recommended change: Insert "(including refresher training)" after the word "trained".

Reason for recommendation: It is believed that scholarship assistance should be awarded to persons taking refresher training. In S. 1453, provision for such assistance is made.

Page 23, line 20–22:

As stated in bill: "(4) scholarships to schools of nursing providing basic or advanced training leading to a degree in nursing;"

Recommended change: Insert "university- or college-controlled" before "schools"; insert "baccalaureate or higher", before "degree"; delete "in nursing" at end of clause.

These lines will then read: "(4) scholarships to university- or college-controlled schools of nursing providing basic or advanced training leading to a baccalaureate or higher degree;"

Reason for recommendation: To conform with changes recommended, page 13, lines 16–21.

Page 25:

Recommended insertion: Insert in Sec. 378. (a) between (2) and (3): "Provide for the establishment or designation of a State advisory committee for each of the fields and composed of representatives of the respective fields of medical, nursing, dental, dental hygiene, sanitary engineering, and public health education which may advise the State agency in the formulation and administration of a plan and shall assist the State agency in the selection of appointees for scholarships.

Reason for recommendation: Such State advisory committees will be informed of the qualifications needed or desirable in prospective students to insure success in their studies and in their respective professions.

Page 26, line 2:

Recommended change: Insert "sex" after "creed".

Reason for recommendation: It is believed that there should be no discrimination because of sex in awarding scholarships.

Page 28, lines 4–7:

As stated in bill: "(b) agreement by the appointee to serve, upon completion of his training (including internships and residencies) one year for each two academic years during which he received the benefits of the scholarship.

Recommended change: Insert after parenthetical phrase "(including internships and residencies)" the words, "in the practice of his profession with respect to which said scholarship was granted." The clause will then read: "(b) agreement by the appointee to serve, upon completion of his training (including internships and residencies) in the practice of his profession with respect to which such scholarship was granted, one year for each two academic years during which he received the benefits of the scholarship."

Page 28, lines 7–16:

Recommended change: Insert period after "scholarship" in line 7 and delete remainder of line 7 and lines 8 through 15 and the word "States" in line 16.

Reason for recommendation: We believe that the provisions contained on page 28, (i) (i), lines 7–16, are directly contrary to American traditions and would defeat the purpose of the bill.

Definitions:

Recommended addition: Insert definitions contained in S. 1453, Sec. 384. Add another definition (c) to read as follows: "(c) The term 'school' includes divisions, departments, and other administrative units in hospitals, colleges, or universities, and also independent schools."

Reason for recommendation: These definitions are important in interpreting terms. With reference to definition (c), educational programs in nursing may be offered by departments or divisions of universities or hospitals. For example, a basic school of nursing may be a department in a hospital.

Page 32, lines 1–6:

As stated in bill: "The twenty appointed members (of the National Council on Education for Health Professions) shall be leaders in the field of medical sciences, education, or public affairs, and ten of the twenty shall be selected from leading authorities in the field of medical, dental, nursing, sanitary engineering, and public health education."

Recommended change: Break up sentence into two sentences, omitting "and" after "public affairs" and changing comma to period. Substitute "at least three" for "ten". Change "authorities in the field" to "authorities in each of the fields." Insert "respectively" after "education" at end of sentence. With those changes, the sentence will read: "The twenty appointed members shall be leaders in the field of medical sciences, education, or public affairs. At least three of the twenty shall be selected from leading authorities in each of the fields of medical, dental, nursing, sanitary engineering, and public health education respectively."

Reason for recommendation: To insure at least three representatives on the National Council on Education for Health Professions from the field of nursing education.

PART B OF BILL S. 1679, TITLE I—CONCERNED WITH PRACTICAL NURSE TRAINING

Page 33, beginning line 22 and with omissions to page 34, line 25:

As stated in bill: "To be approved under this part, a State plan for practical nurse training must provide * * * (6) for the availability of professional education courses necessary for the certification of teachers, supervisors, and directors of practical nurse training; (7) that such training leading to certification of teachers, supervisors, and directors shall be given under the auspices of the State board (for vocational education) and, except in the case of teachers of related subjects, only to persons who have had adequate experience in nursing;"

Recommended change: Delete all of (6) and all of (7).

Reason for recommendation: Courses preparing professional nurses as teachers, supervisors, and directors of practical nurse training should be made available in schools of nursing and other administrative units of universities offering advanced training to professional graduate nurses. Such courses are already in existence and under the direction of a professional nursing group conversant with the function and educational needs of professional nursing personnel engaged in practical nurse training. Provision for the preparation of teachers, supervisors, and directors of practical nurse training in such courses is made on page 13 of this bill.

Page 33, beginning line 22 and with omissions to page 35, line 3:

As stated in bill: "* * * a State plan for practical nurse training must provide * * * (8) duties and qualifications for teachers, teacher-trainers, supervisors and directors, and plans for the supervision and direction of practical nurse training;"

Recommended change: Delete "teacher-trainers".

Reason for recommendation: Professional nursing personnel receive their preparation for teaching, supervising, and directing practical nurse training in nursing administrative units in universities. The faculty of such units constitute the teacher-trainer group for practical nurse training.

Page 33, line 22 and with ommissions to page 35, line 7:

As stated in bill: "* * * a State plan for practical nurse training must provide * * * (9) for an advisory council composed of not more than ten nor less than six persons, including not less than two registered nurses, a physician, an educator, a hospital administrator, and such other persons the State may desire, * * *"

Recommended change: Insert "professional" after "registered"; insert "a practical nurse (who shall be a licensed practical nurse, if the State in which she practices shall have provided for the licensure of practical nurses)" before "a physician". With these changes the above lines will read as follows:

"* * * a State plan for practical nurse training must provide * * * (9) for an advisory council composed of not more than ten nor less than six persons, including not less than two registered professional nurses, a practical nurse (who shall be a licensed practical nurse if the State in which she practices shall have provided for the licensure of practical nurses), a physician, an educator, a hospital administrator, and such other persons the State may desire, * * *"

Reason for recommendation: This recommendation is made in the belief that practical nurses should be represented on a State advisory council on practical nurse training, inasmuch as a qualified practical nurse could make a valuable contribution to the work of such council.

Page 36, lines 14–17:

As stated in bill: "(c) The funds appropriated * * * may be used * * * in meeting the direct costs of maintaining an adequate program of administration, supervision, and teacher-training;"

Recommended change: Delete "and teacher training".

Reason for recommendation: Given in first recommendation at top of this page.

Page 36, line 14 and with omissions to page 37, line 11:

As stated in bill: "(c) The funds appropriated * * * may be used * * * for paying the cost of practical nurse training, under the supervision or control of the State board or local boards of vocational education, in public or nonprofit private hospitals exempt from income tax under section 101 of the Internal Revenue Code:"

Recommended change: Insert "clinical" before "training."

Reason for recommendation: As the statement is written in the bill it would appear that it could be interpreted to mean that the entire practical nurse training program could be carried on in public or nonprofit hospitals, under the supervision or control of the State board or local boards of vocatinal education. The statement properly refers to the clinical part of training only. By inserting "clinical" correct interpretation is assured.

Page 38, lines 21–24:

As stated in bill—"(c) Funds appropriated pursuant to this part shall not be paid to any State until a State supervisor of practical nurse training meeting the minimum requirements established in the State plan has been employed."

Recommended change: These lines to read as follows: "(c) Funds appropriated pursuant to this part shall not be paid to any State until a registered professional nurse has been appointed as a State supervisor of practical nurse training who shall meet the minimum requirements established in the State plan."

Reason for change—For the sound development of practical nursing in the several States it is essential that the State supervisor be a registered professional nurse. The registered professional nurse will not only be aware of the problems in practical nurse training but also of the articulation of practical nursing in the total nursing field.

Senator MURRAY. From time to time, Mrs. Spalding, questions have been raised here as to the quality of training given by certain schools of nursing. An article has appeared in the Woman's Home Companion indicating that some are sources of cheap hospital labor rather than schools. Are you familiar with that article that appeared in the Woman's Home Companion?

Mrs. SPALDING. I have read it superficially. I think I have a general idea of what is included.

Senator MURRAY. Do you have any comment to make on that, about whether or not there is any truth in that argument?

Mr. SPALDING. I am not sure that I have read it carefully enough to make an analysis at this time, Mr. Chairman.

Senator MURRAY. Would you regard withholding financial aid from poor schools as indicating an attempt at Federal interference in the education program?

Mrs. SPALDING. I would not think that was true if the criteria that were used were determined by the nursing profession.

Senator MURRAY. I can see no reason why there should be any attempt on the part of the Government to interfere or introduce any Federal regimentation into the schools. I should think that the Government would be anxious to cooperate in bringing about the best results. I do not see what object they could have in trying to regiment the schools.

Mrs. SPALDING. We have had considerable experience, I think, in the nursing profession, with the Federal Government, and I believe we would have no fear because our association with the Federal Government in connection with nursing education has been very pleasant, and as long as the principles and practices approved by the profession concerned are used by the governmental unit which is administering the program, I would think that the nursing profession would have no fear.

Another point I think of, Mr. Chairman. The provision in title I of S. 1679 for advisory and technical committees as well as representation on the Council certainly ought to safeguard from any Government interference.

Senator MURRAY. All these matters will be given very careful study when we come to write up the bill.

I notice in the morning's paper there is an announcement of the appointment of the first woman Assistant Surgeon General of the United States Public Health Service in history. I understand she is an expert in nurse training. Have you noticed that?

Mrs. SPALDING. Yes; and we were very pleased to see that announcement, and I personally was pleased, as I was her associate during the time of the Cadet Nurse Corps program.

Senator MURRAY. I wish to congratulate the women in the progress they are making in this field, and I certainly hope that this new appointee will make a splendid record to justify her appointment, and also to show the great part the women are playing in this field.

If you have any others here now that wish to make any additional comments in connection with your testimony, we will be glad to hear from them.

Mrs. SPALDING. Do you have anything to add, Miss Pfefferkorn?

Miss PFEFFERKORN. I do not think I have anything additional, Mr. Chairman.

Senator MURRAY. You have no prepared statement you wish to submit?

Miss PFEFFERKORN. No; I have no prepared statement.

Mrs. DAVIES. The National Organization for Public Health Nursing, Inc., did file a statement endorsing the statement of the American Nurses' Association and also making comment with respect to the testimony that was presented by the Association of Schools of Public Health.

Senator MURRAY. Yes; we have that statement and it will be placed in the record at this point.

(The statement above referred to is as follows:)

STATEMENT BY THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

The National Organization for Public Health Nursing includes as members 9,000 public-health nurses, 400 public-health nursing agencies, and 1,000 other persons interested as private citizens in the improvement of public-health nursing throughout the Nation.

Although the National Organization for Public Health Nursing is presenting no separate testimony at this hearing, it does wish to go on record as supporting the testimony of two other groups:

1. *The statement of the American Nurses Association.*—The board of directors of NOPHN has by official action approved the objectives to be attained through Federal aid-to-nursing education. Representatives of our organization have assisted with the preparation of the testimony which is to be presented to the subcommittee on health of the Senate Committee on Labor and Public Welfare by Mrs. Eugenia K. Spalding for the American Nurses Association. The NOPHN endores the statement of the American Nurses Association to the Senate Committee on Labor and Public Welfare on bill S. 1679, title I, and on bill S. 1581, title VI.

2. *The statement of the Association of Schools of Public Health.*—We are also familiar with the testimony to be presented by Brig. Gen. James S. Simmons, United States Army (retired), dean of the Harvard School of Public Health and president of the Association of Schools of Public Health. Any and all figures contained in General Simmons statement that relate to public-health nursing meet with the approval of NOPHN.

The NOPHN is particularly interested in the support of those measures which will provide for the education in colleges and universities of public-health nurses to meet beginning and advanced responsibilities for public-health nursing care.

Senator MURRAY. Any others here that wish to make a statement at this time?

You will all be invited, any of you that wish, to sit in with our staff to help us in this matter. We will be glad to have your help. I think you have made a substantial contribution by the statement you have given us here this morning, and I am sure with your help we will be able to work out a bill with the proper language that will be of value to the country.

Mrs. SPALDING. Thank you.

I perhaps did not make it clear as to what my position at the present time was this morning when I indicated my relationship to this, and perhaps I should have. I am at the present time director of the division of nursing education at Indiana University, Bloomington, Ind.

Senator MURRAY. Thank you very much for your statement.

Mrs. SPALDING. Thank you.

Senator MURRAY. Ella M. Thompson is the next witness, representing the National Association for Practical Nursing Education. You may state your name and the organization that you represent.

STATEMENT OF ELLA M. THOMPSON, PRESIDENT, NATIONAL ASSOCIATION FOR PRACTICAL NURSING EDUCATION, NEW YORK, N. Y.

Miss THOMPSON. My name is Ella Thompson, and I represent the National Association for Practical Nursing Education.

Senator MURRAY. You may proceed.

Miss THOMPSON. The National Association for Practical Nurse Education, which I am representing, is a national nursing organization, organized in 1942 for the promotion of sound practical-nurse education. Professional nurses, physicians, hospital administrators, and lay people actively interested in any phase of the development of practical-nurse education and practical nurses who are graduates of approved practical-nursing schools are eligible for active membership: 22 State associations of practical nurses have group membership, representing the interests of over 5,000 practical nurses.

This testimony which I am presenting relatives only to part B, title I, of S. 1679, and represents the opinion of the association.

We believe that practical nursing is a needed community service which should be given by adequately trained people. An estimated 23,000,000 patients with long-term illness in this country require nursing care that can be given by the practical nurse. Plans for expanded hospital facilities and the increasing use of practical nurses for the care of convalescent patients in these institutions will require many more trained practical nurses than are now available. The supply is totally inadequate now for the present needs of these institutions. And the trained practical nurse is recognized as an indispensable member of the nursing team.

At the present time there are approximately 76 practical-nursing schools approved by State licensing authorities or by the National Association for Practical Nurse Education. Since the first school was established in 1897, 13,300 practical nurses have been graduated from these schools. In order to meet the nursing needs of the country in the next 5 years, it has been estimated that we should produce 10,000 trained practical nurses annually. In 1948, 71 schools graduated 1,600 practical nurses. It is obvious that we must augment enrollment in the existing schools and that the number of approved schools must be greatly increased in order to meet the nursing needs of the Nation.

The National Association for Practical Nurse Education has gone on record as approving the promotion of practical-nurse education under the auspices of vocational education. We believe that such sponsorship insures a sound educational program for the practical-nurse student and prevents exploitation for the service needs of an institution during the training period.

Our association is cosponsor, with the Department of Public Instruction and the Michigan Nursing Center Association, of a 3-year experiment to develop practical-nurse education on a State-wide basis in Michigan. This project would not have been possible without the W. K. Kellogg Foundation annual grant-in-aid of $45,000, which provided the additional funds needed for school equipment and changes in the physical plants. We feel that financial aid beyond that which State and local vocational education departments are able to give is necessary to promote similar programs in other States.

With this aid approximately 500 practical nurses have been enrolled in the schools and are graduating. That represents a third of the entire number that were graduated last year in the country—in the program of one State.

If we are to produce the needed number of practical nurses Federal aid will be required to equip schools, promote recruitment of students, and provide adequately prepared directors and instructors for these schools.

The uneven distribution of the existing schools often makes it necessary for prospective students to travel across several States to secure practical-nurse training. Plans for developing schools should be under way in many States that now offer no opportunity for this type of education. The variations in State appropriations for vocational education make it difficult for State and local boards of education to develop practical-nurse-training programs even though they may be intensely interested in doing so.

The hundreds of requests received in our office for information on all phases of practical-nurse education, and for consultant service in establishing training programs, testify to the widespread interest in preparing more and better practical nurses. The census of 1940 reported 200,000 people—men and women—as actively engaged in the practice of nursing at this level. Since only 13,000 practical nurses have had approved training, it is evident that the public is receiving nursing service given by untrained people.

We would like to point out that S. 1679 has not written into it a provision for professional nurse direction of the practical-nurse- training program in the Office of Education of the Federal Security Agency. We know that they are interested in providing such direction, although that provision is not written into the bill at the present time. And we would like to see such a provision written in.

We hope that such direction would be provided at both National and State levels.

We are very appreciative of the opportunity to testify and to make our plea, and to endorse also the plan for promoting practical-nurse education under vocational-education auspices.

Senator MURRAY. Thank you for your testimony. I think this is a very important program we are working on, and I am sure that your testimony and the assistance you will give our staff will be very helpful to us.

Miss THOMPSON. We will be very happy to do anything we can.

Senator MURRAY. The next witness is Chancellor R. G. Gustavson, of the University of Nebraska.

STATEMENT OF CHANCELLOR R. G. GUSTAVSON, UNIVERSITY OF NEBRASKA, ON BEHALF OF ASSOCIATION OF AMERICAN UNIVERSITIES

Mr. GUSTAVSON. Mr. Chairman and members of the committee, I appreciate very much the opportunity to appear before this committee this morning in behalf of the Association of American Universities.

Unfortunately the replies to the questionnaires which were sent out by the association did not get back in time for me to get them summarized in the form of a statement for the committee, and I should like to ask the privilege to submit that.

Senator MURRAY. You may submit it and it may be printed in the record in connection with your statement this morning.

Mr. GUSTAVSON. Thank you.

I am Chancellor R. G. Gustavson of the University of Nebraska, and I am representing the Association of American Universities.

The Association of American Universities is made up of both the private endowed universities and the State universities. It includes such universities as Harvard, Yale, Brown, Johns Hopkins, the University of Chicago, University of Pennsylvania, and Columbia University, representing the endowed colleges. And on the other hand, it includes such State universities as the University of Wisconsin, University of Illinois, University of Michigan, Minnesota, Cornell, Iowa, Kansas, Missouri, Nebraska, and California. That is not the complete list but it is typical of the institutions that I am representing.

Our association has given much time and thought to the problem which is presented in the bills that we have before us this morning, and I am referring my remarks particularly to S. 1679.

We recognize the need for a larger number of physicians, and we also recognize the acute need in the rural areas of our country. And in a State such as Nebraska, of course, this is very close to our hearts.

I should like to say that at the present moment the number of physicians being graduated from our universities is low. For example, in our graduating class just last Monday we graduated 52 physicians, which is almost half of what we should be graduating. This is due to the fact that during the latter part of the war the Selective Service committees did not defer premedical students to the extent that perhaps they should have, and we are now paying for our lack of foresight at that time.

There is a very large number of young people that are asking for entrance to our medical schools who cannot now be accommodated because of the lack of facilities to give them training.

I did want to call your attention, Mr. Chairman, and the attention of the committee, to the fact that our universities, however, have tried to take a maximum advantage of this large number that are applying in doing a very careful job of selection. And I should like to just say for your information that whereas the number of students failing in the past would sometimes be from 10 to 25 percent, due to the better job of selection that one can do with a larger number of applicants, the number of failures is now very, very small indeed.

I was interested in noticing, for example, in our present freshman class at the University of Nebraska, which numbers 85 members now, there is not a single failure, which is a tribute to the selection process.

Senator MURRAY. Yes.

Mr. GUSTAVSON. I thought you would be interested in knowing that this better job of selection of itself means an increase in the number of physicians that are available because, after all, the number of physicians available is determined not alone by the number that enter but by the number who graduate.

Senator MURRAY. That is right.

Mr. GUSTAVSON. The rising costs of medical education are alarming and are a source of great concern to all of us who are operating medical schools.

There are a number of schools, of which my university is a type, where we have depended upon the voluntary help of the clinical profession. They have carried a very substantial part of the burden, and I must say they have carried it very well.

Now, due to the excessive demands on their time, the amount of time which they are able to give to the universities has diminished, and so we find ourselves in this position which is embarrassing. Physicians will volunteer and do so with the best of intentions to carry on on a voluntary basis for the universities a class scheduled, let us say, at 10 o'clock in the morning. That busy physician has an emergency operation, and a notice comes out that he cannot meet his engagement, and so you make some arrangement for the moment. But this, I am sure we all regret, because it means that the quality of the instruction that we are able to give is not what it should be.

For this reason we are all facing the problem of having an increased number of full-time men and part-time men. Because when you have men on your staff, either full time or part time, then you can look upon the appointment as one that you can hold the physician to, and that means, of course, that the instruction is made very much better.

I do not want this to be taken as a criticism of the volunteer physician but rather as a statement of the complex situation which is simply a reality and which is a part of our problem.

The scholarships that are proposed meet with our very hearty approval.

Medical education is very expensive, and for that reason unless we are able to make scholarships available to those who have the capacity to carry on in the medical schools, and who do not have the financial resources, if that is not possible, then we get an economic selection in making our choice of physicians. And that unquestionably means that we are overlooking the possibility of getting very good minds that could be of great service to our country.

During the present academic year 78 schools that are colleges of medicine are operating on budgets totaling about $51,000,000, of which $12,800,000 is derived from student fees; $20,700,000 from endowment income, gifts, and general university funds for deficit financing; and $17,500,000 from tax resources.

The cost of educating a medical student per year varies a great deal depending almost entirely on two factors: One, the cost of research projects that are being carried on; and, two, the number of full-time teaching members of the faculty that one possesses.

The contribution that is made by the volunteer physician should not be overlooked because the volunteer physician who is engaged in the practice of medicine has a contribution to make which we recognize as very, very valuable. And few of us, I think, look forward to the day when this volunteer physician is not intimately associated with our medical college.

Senator Murray. I think there is a lot of merit to that statement. In the legal profession, I know, in many of the law schools some of the professors are in actual practice.

Mr. Gustavson. Yes.

Senator Murray. In that way I think they are able to give something to the students that they would not get from professors who are not engaged actually in the practice of law. I think it is true of medicine also.

Mr. Gustavson. Very true.

We find that some of our very best teachers are these volunteer physicians.

With respect to the $300 subsidy per student per year, it is the feeling of our association that this sum is not adequate, and we would very much like to see that increased.

When I speak of the cost of medical education, I think you might be interested in this: I made a calculation of our costs at Nebraska for 1 year in the college of medicine and compared it then with the cost of primary education. And it just turns out that you can send a student to school for 1 year of kindergarten up through the high school for just what it costs you to send a medical student to the university for 1 year.

It is the hope of our association that we can increase the number of medical schools and the opportunity available for medical students. On the other hand, we hope that the expansion will not take place so rapidly that it will take place at the expense of the quality of instruction.

I can summarize, I think, Mr. Chairman, the opinion of our association when I say that there is a definite need now for Federal aid to medical education, provided the educational and administrative policies can continue to rest in the hands of the medical colleges without political influence. I think the bill adequately provides for that.

May I say parenthetically that those of us who have been connected with the land grant colleges in agriculture have never had any interference and do not believe that that fear of interference is very well founded.

Senator MURRAY. I am very glad to hear you say that, Doctor. That fear has been expressed so much that it is very fine to hear someone who has had actual experience and has found there has been no attempt to make any interference.

Mr. GUSTAVSON. I should also like to say our experience with the Public Health Service in grants for research has also been a very happy one.

We sincerely hope that Federal aid to medical education will not decrease private and State aid as to these schools. Whether that happens or not, of course, will be determined, I think, by how clearly we are able to keep before the public the need of good medical education.

Our association feels that aid to students should have a need qualification. If there is any indentured service it must have an escape clause. Scholarships should be awarded to those who are already admitted to medical school. Many of our people prefer aid in terms of loans.

We do feel that the medical schools themselves can do a great deal toward getting our medical student interested in service to the rural area, and I thought you might be interested in this as a part of the background for your work: At the University of Nebraska we have sent our seniors, between the junior and senior year, out into the rural areas to actually live with a physician in a small town and to work with him so that he gets a picture of what the life of a physician is in a small community. He gets an opportunity to see the intimate relations that exist between such a physician and the people, which we believe allows him to see a quality of service and a kind of life that will appeal to him.

Lastly attention must be given to the maintenance of standards in the present medical school operation. Incentives for new students must not be so attractive as to cause expansion beyond facilities and at too rapid a rate.

This reflects what I said in the beginning, this fact that the services from the volunteer physician by virtue of the heavy demands is threatened at the moment. And we see that the problem of personnel in the teaching phase of our university is critical because this determines in the last analysis how good a job we can do.

May I say again, Mr. Chairman, how much I appreciate the opportunity to appear before you without a prepared manuscript, and I shall submit that immediately.

Senator MURRAY. You suggested that $300 subsidy which is to be provided is not sufficient.

Mr. GUSTAVSON. That is the opinion of our association, Mr. Chairman.

Senator MURRAY. Will you in your statement that you are going to submit give us some development of that idea?

Mr. GUSTAVSON. Yes.

Senator MURRAY. And what you think should be done?

Mr. GUSTAVSON. I shall be very happy to because we have that figure.

Senator MURRAY. Thank you very much for your statement.

Senator MURRAY. I should like to have inserted in the record at this point a letter and a statement addressed to Senator Elbert D. Thomas, of Utah, by Dora Goldstine, president of the American Association of Medical Social Workers. The statement sets forth the views of that organization on education of health personnel.

(The letter and statement are as follows:)

THE AMERICAN ASSOCIATION OF MEDICAL SOCIAL WORKERS, INC.,
Washington 5, D. C., June 2, 1949.

Hon. ELBERT D. THOMAS,
United States Senate, Washington, D. C.

MY DEAR SENATOR: I am enclosing a statement which our organization would like to have considered by your committee in the hearings on Senate bill 1679, which you have introduced in the present session of the Congress.

We are particularly concerned about title I, "Education of Health Personnel," because, although medical social work might be considered a "related profession," the provisions for scholarships and for grants do not specifically include medical social-work students or the accredited schools of social work (cf. secs. 371, 372, 376, 377, 378). We should like to see these sections amended to include social-work students and accredited schools of social work.

The bearing of social and economic factors on illness and on the individual's use of medical care has long been recognized as significant, and medical social workers have been employed by hospitals and clinics, as well as numerous public-health agencies, for almost 50 years. That this service is an essential part of medical care is attested to by the fact that the demand for qualified medical social workers has greatly exceeded the supply for a period of at least 10 years, and currently an acute shortage exists. Only by grants to expand educational facilities and by scholarships to qualified students can this essential group of health personnel be trained, and we believe that in any legislation for expanding the supply of health personnel medical social workers should be specifically included.

The necessity for an increase in the several classes of health personnel enumerated in title I of this bill has long been recognized and you and your colleagues are to be commended for the broad scope of these provisions. We hope that serious consideration can be given also to the necessity for including medical social workers in the provisions and that this title can be so amended.

We shall very much appreciate your use of the enclosed statement as representing the testimony of the American Association of Medical Social Workers.

Sincerely yours,

DORA GOLDSTINE, *President.*

STATEMENT REGARDING THE INCLUSION OF MEDICAL SOCIAL WORKERS IN FEDERAL GRANTS FOR TRAINING OF HEALTH PERSONNEL UNDER TITLE I OF SENATE BILL 1679

Medical social work as a profession began in 1905 because of the recognition by the medical profession that social factors, personal and environmental, contributed to creating illness and were a component to be considered in preventing and treating illness. Three medical teaching centers (hospitals and clinics), in Boston, Baltimore, and Indianapolis, led this development. In the 1930's, with the inauguration of Federal social security measures, medical social service became part of Federal, State, and local medical care and health programs. Experience over the years has shown that the type of personnel best able to help the physician and the patient in meeting personal and environmental situations interfering with or complicating the medical treatment is the person who has knowledge of the social needs of individuals, including the psychological effects of illness; knowledge of the medical contribution and of how to work in a medical setting, and knowledge of the most effective use of community resources. This training requires 2 years of full-time graduate study in an accredited school of social work[1] with a medical social sequence approved by the American Association of Medical Social Workers, the professional membership organization interested in setting educational and practice standards.

The inclusion of the medical social sequence as a part of the graduate curriculum in social work has been slow but steady, limited partly by the fact few scholarships in medical social work have been available. When such have been offered, as during World War II by the American Red Cross in order to recruit personnel, and since 1944 by the National Foundation for Infantile Paralysis in order to have medical social personnel for programs concerned with crippled children, the number of students enrolling in this specialty has increased proportionately. It might be pointed out here that when public funds were made available for social workers under the National Mental Health Act, there likewise was a marked increase in enrollment.

There are three times as many openings today for the qualified graduate as schools and employment facilities are able to fill and 600 graduates a year could be satisfactorily placed in positions in hospitals or in public health programs. The following figures show the growth of the profession:

1. Accredited schools of social work giving the medical social sequence:

(*a*) Approved schools in 1930	8
(*b*) New approved schools since close of World War II	5
(*c*) Approved schools at present	23

2. Total number of medical social workers in training:

(*a*) Length of course	2 academic years (18 mos.) of full-time graduate study.

(*b*) Number of graduates in:

1930	37	1948	336
1935	77	1949 (estimated)	350
1940	97	1950 (estimated)	380
1946	184	1951 (estimated)	450
1947	228		

3. Estimated number of medical social workers now active:

(*a*) Total	2,365
(*b*) In hospitals (public and private, including Army, Navy and Veterans' Administration)	1,975
(*c*) In official public health agencies	325
(*d*) In voluntary public health agencies	25
(e) In private practice	(1)
(*f*) Other	45

(1) Teachers in accredited schools of social work.
(2) Health divisions of councils of social agencies.

[1] Not known.

The number, 2,365, represents the present membership of the AAMSW. The number of practicing medical social workers not members of this organization is not known.

4. (*a*) Estimated total number needed by 1960	6,000
(*b*) Average increase in admissions per year to meet 1960 needs	360

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[1] The American Association of Schools of Social Work is the recognized professional organization for accrediting the educational curriculum for all classes of social work instruction in graduate schools of social work.

Although 600 graduates a year could be clased, it should be noted that such an increase in student enrollment would require tremendous expansion in existing educational facilities. This is being met partially by the slow but steady growth in the number of schools offering the medical social curriculum. Although it might be met also to some extent by an increase in income to the schools from the enrollment of a larger number of students holding scholarships, additional funds would be required to employ more faculty, and to reimburse agencies for the instruction of students in field work (i. e., practice experience under supervision).

5. Financial situation of schools:

(*a*) Estimated annual operating expense per student[1] (excluding gifts and grants).	$902.
(*b*) Estimated annual income per student from tuition and fees.	Difficult to estimate since 85 percent of social work student's income is from sources other than the student.

6. Capital expansion:

(*a*) Estimated cost of improvements and modernization of existing facilities to maintain adequate standards for present enrollment.	$300,000.
(*b*) Estimated cost of additional facilities to train personnel needed by 1960:	
Buildings	$21,120,000.
Instruction, etc	$10,824,000.

The figures used for computing the financial data were secured from Dr. Ernest V. Hollis, Chief of College Administration, United States Office of Education, Federal Security Agency, and director of the current study on social work education for the National Council on Social Work Education.

Senator MURRAY. This will conclude the hearing this morning. We will start our informal conferences on these bills that we have been discussing on Wednesday. There will be no further hearings until a week from next Monday.

(Whereupon, at 11:15 a. m., the hearing was recessed to reconvene at 10 a. m. on Monday, June 20, 1949.)

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[1] This computation is based upon a budget which considers plant facilities as well as salaries for instructors.

NATIONAL HEALTH PROGRAM OF 1949

MONDAY, JUNE 20, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

President: Senator Murray.

Also present: Messrs. Rodgers, assistant committee clerk; Reidy and Sneed, committee consultants.

Senator Murray. The hearing will come to order.

Dr. Baehr is a witness here this morning. I understand that he wishes to go on the stand first because he has an engagement.

You may take the stand, Doctor. State your names, the position you hold, the organization you represent, or anything about your background you wish to have in the record.

STATEMENT OF GEORGE BAEHR, REPRESENTING NEW YORK ACADEMY OF MEDICINE; ACCOMPANIED BY BENJAMIN WATSON, PRESIDENT, NEW YORK ACADEMY OF MEDICINE; AND HOWARD CRAIG, DIRECTOR, NEW YORK ACADEMY OF MEDICINE

Dr. Baehr. I am Dr. George Baehr, representing the New York Academy of Medicine. I should like to introduce my successor as president of the academy, Dr. Benjamin Watson, who is behind me, and Dr. Howard Craig, who is the director of the academy. I am clinical professor of medicine at Columbia University. I am chief of medicine and director of clinical research at the Mount Sinai Hospital, New York City, and consultant to four other hospitals in the New York area.

Senator Murray. You have been here before.

Dr. Baehr. I have, on two previous occasions, 1946 and 1947.

Senator Murray. We have always enjoyed hearing you, Doctor, and we are glad to have you here today.

Dr. Baehr. Thank you, Senator.

Senator Murray. The other gentlemen whom you have introduced, will they participate in the statement that you are making this morning?

Dr. Baehr. Only if you request them to, but I am authorized to speak on behalf of the academy.

Senator Murray. I see. You may proceed with your statement.

Dr. Baehr. Dr. Howard Craig, who is with me, and Dr. Watson and I are pleased with this opportunity to appear before you at your invitation to testify on behalf of the New York Academy of Medicine. To save time, we refer you to the statements and testimony which I gave as president of the academy at previous hearings before this committee on May 24, 1946 (pp. 2060 to 2079) and on May 22, 1947 (pp. 121 to 164. For the benefit of those Senators who were not members of this Senate committee in those years, I should like to give a condensed version of that testimony as a brief preamble to comments on the health bills before the Eighty-first Congress.

The membership of the academy consists of about 2,500 fellows and associate fellows, among whom are many of the most distinguished practicing physicians, specialists, medical educators, and medical scientists, not only from the New York area but from many parts of the country. Its primary purposes are the promotion of public health, the extension of medical education, the advancement of the medical sciences, and the improvement of medical practice. In line with these purposes, it maintains one of the great medical libraries of the world, to which the general public and the entire medical profession have free access.

It has been our desire, like yours, to find the best means of bringing the modern benefits of preventive and curative medicine to all the people of our country, rural and urban. We are not interested in maintaining the status quo and are prepared to consider any changes in the methods of rendering medical services and of payment for medical care which may be better for the people. Accordingly, a special Academy Committee on Medicine and the Changing Order recently completed an intensive 4-year study, the factual material of which has been assembled in 11 monographs published by the Commonwealth Fund. A twelfth volume, entitled "Medicine in the Changing Order," contains the summary report and the Academy's findings and recommendations.

In brief, I should like to state that the Academy is fully cognizant of the many lacks in medical care which now exist throughout the United States. We are in complete agreement on the principle that the health of the people is a matter of national concern and that every effort should be made to provide all our people with adequate medical care. From our experience and our study of the problem, we feel certain that national compulsory medical insurance as proposed in the Thomas bill, S. 1679, would result in most detrimental changes in medical practice and would harm the public. We are also convinced that the objectives which the proponents of this bill have in mind, and which we share, can be achieved more effectively by procedures which are more orderly, progressive, and far less hazardous.

National compulsory medical insurance would indeed provide the funds with which to pay for medical care wherever it is available. Probably 80,000,000 people or more would pay in advance through pay-roll reductions or other contributory methods for home and office care; laboratory, diagnostic, and consulting services; and specialists' services outside and within hospitals. Yet, in many parts of our country, either such services are unavailable or only an inadequate fragment can at present be obtained. Our Government cannot collect the money in advance and not be prepared to deliver the goods promptly on demand.

These deficiencies in the availability of adequate medical care are now recognized realistically in S. 1679 as they are in the other omnibus health bills before the Congress. Provision is therefore made in other titles of this and other bills for aid to medical, dental, and nursing education; for encouragement of a better distribution of medical services, especially in rural areas; for a more rapid construction of physical facilities, et cetera. However, it may take a generation of consistent effort by Federal, State, and local authorities before the required amount of medical personnel and physical facilities can be developed, which would permit our Government and private agencies to fulfill their joint obligation to the people if Nation-wide compulsory medical insurance were enacted.

In regard to the gross inequalities among the States in just one branch of medical practice, I invite your attention to the recent report by the American Academy of Pediatrics on Child Health Services and Pediatric Education, published by the Commonwealth Fund. It should be obvious that we in this country, with our 48 very different States and their inequalities, are far from being ready for such a momentous step.

A second fundamental fault which the proponents of compulsory medical insurance have not faced is that the method of remunerating physicians by the payment of a fee for each service, a method which almost the entire profession of this country will choose because it is more profitable, will result in a gigantic, Nation-wide "medical racket" involving patients and doctors alike. Under a "fee for service" system of payment by an insurance fund, the pressure of subscribers for services and the financial rewards to the physician for mere volume of services constitute a combination of influences difficult to resist. The inevitable result is superficial performance and a disastrous deterioration in the standards and ideals of medical practice throughout the Nation.

The alternative method of payment proposed is S. 1679, namely, capitation, whereby an annual payment is made to the physician for each insured patient on his panel, would be acceptable in this country only to some medical-practice groups. It is quite obvious to those who know something about medical administration under existing prepayment plans that significant changes must occur in the organization of medical practice and in the methods of payment before comprehensive medical services, preventive and curative, can be provided to persons who prepay their medical needs under any insurance plan, compulsory or voluntary. S. 1679 fails to provide financial or other material encouragement to physicians to organize themselves into medical group-practice units. The Humphrey bill (S. 1805) wisely recognizes this need but limits assistance to medical groups which are part of cooperatives. Its provisions should be extended to medical-practice groups serving nonprofit medical-insurance plans which may not be cooperatives.

The academy has proposed a much better and far less hazardous alternative to national compulsory medical insurance, which would permit us to build upon the excellent structure of American medicine and extend it progressively and as rapidly as possible to all the people of this country. At the hearings of this Senate committee in 1946 and 1947, we urged the enactment of legislation to provide Federal grants-in-aid to the States for the study of State and local needs and the development of State and local programs designed to correct these deficiencies in accordance with acceptable Federal standards. In this country, the provision of medical care has been and will always continue to be a local responsibility except for such conditions as mental disorders, tuberculosis, and chronic illnesses which require prolonged hospitalization and must largely be a responsibilty of the State. In every locality in which medical personnel and facilities are seriously deficient, the reasons are, as a rule, ignorance, lack of financial resources, or geography. It should be the responsibility of Government to aid in correcting the major existing deficiencies by providing sufficient State and Federal assistance to raise local medical resources to a desirable level. Enetirely different procedures will be required in some rural areas from those in urban centers and not all urban communities need identical treatment.

In order to encourage the people to contribute as adequately as possible to the support of their own local medical services and facilities, Federal and State aid will be required to assist them in establishing and maintaining local, regional, or State-wide prepayment plans for medical care.

The academy is opposed to S. 1679 with its program of national compulsory medical insurance because it involves precipitate changes in medical practice of Nation-wide scope which would be irreversible. It would not be averse to experimentation with such a procedure over a limited geographic area. The academy prefers voluntary non-profit-medical-insurance plans because they are flexible and permit local initiative and experimentation. Such plans cannot be designed primarily for the indigent or medically indigent, but are required for people with moderate incomes. The contributory premiums for families on relief should be paid by Government, for those temporarily unemployed, by the unemployment insurance funds, as in the Hill bill (S. 1456). The contributions by persons gainfully employed should be proportional to their earnings up to a definite income ceiling, as in the Flanders-Ives bill, so that the lowest income group can afford to subscribe.

It is important that the Federal and State Governments contribute a fraction of the total operational cost out of general tax funds as grants-in-aid and that premium payments be deductible on income tax returns, so that there will be a compelling incentive for all people to subscribe to the plans. This would also provide the necessary financial stability to the plans during periods of business recession when wage levels fall and premium income is reduced.

The academy is also convinced that it is essential that such prepayment plans should meet the following requirements:

1. They should maintain the professional and operational standards required by Federal and State health councils;
2. They should provide financial and other incentives to physicians which will encourage them to organize themselves into medical practice groups. Such medical groups can provide comprehensive medical care, preventive as well as curative, and can effectively render such services to subscribers in return for capitation payments. Medical practice groups can also serve as the yardstick with which to measure the performance of "solo" practitioners and specialists remunerated on a fee-for-service or capitation basis;

3. They should provide similar incentives to the staffs of teaching hospitals and to other approved hospitals and health centers to organize themselves into units for medical group practice related to the general physicians in adjacent urban and rural areas. In this manner young physicians will learn to appreciate the financial, professional, and educational advantages of group practice, to the end that the practice of medicine may be gradually transformed in future years, at least in part, to a form which can maintain high standards of professional service and be capable of functioning more efficiently and economically under prepayment plans than under the present method of "solo" practice. In this manner evolutionary changes in medical practice can be iniated without any sudden and violent dislocation of the medical profession or a lowering of medical standards and ideals.

4. They should develop a regional interrelationship of medical centers and teaching hospitals to smaller institutions, local health centers, and even individual physicians in outlying communities.

For the reasons stated, the academy wishes to record its disapproval of S. 1679 (Thomas bill). It approves in principle, S. 1456 (Hill bill), S. 1581 (Taft-Smith-Donnell bill), S. 1805 (Humphrey bill), and S. 1970 (Flanders-Ives bill), with reservations in regard to details in all these bills.

S. 1456 and S. 1581 are based too heavily upon a program designed primarily for the indigent and medically indigent. A medical-care plan must provide for the needs of all people of moderate income and, of course, include the indigent in these benefits. A means test for eligibility to a prepayment plan is impractical and undesirable if the plan is ultimately intended to include a major part of the total population.

S. 1456 fails to make any provision for comprehensive medical services to subscribers. Prepayment for medical care of conditions which require hospitalization or other limited medical benefits are desirable as incentives to thrift but they have no significant influence upon the extension of medical care or upon the quality of medical services. Such limited benefit plans certainly plan no role whatever in preventive medicine and have little influence upon encouraging prompt and early recognition of disease. Yet this is rapidly becoming a matter of urgency in view of our aging population and the increasing number of diseases which can be cured or arrested when detected in an early stage. We therefore recommend that provision be included for comprehensive medical services wherever they can be made available.

The experience of the health insurance plan of greater New York—I am chairman of the board of directors—which provides complete medical service to its subscribers in return for a premium without any financial or other deterrent, indicates that under these favorable circumstances less than 10 percent of the total medical services are for patients in hospitals and over 90 percent are rendered in physicians' offices, health centers, and in the subscribers' homes.

The development of diagnostic clinics (S. 1456 and S. 1581) as aids to early diagnosis is praiseworthy. I established such a consultation service at the Mount Sinai Hospital, New York, for persons of moderate means almost 20 years ago, which has been in successful operation on an all-inclusive flat-fee basis since that time. In spite of its demonstrated value, I can tell you from my experience that the support of diagnostic clincs by a prepayment plan as an isolated item in medical care is actuarially unsound. Such diagnostic and consulting facilities can be operated under prepaid support only when they are part of a comprehensive medical-care plan.

S. 1970 (Flanders-Ives bill) comes nearest to meeting all the academy's requirements for a voluntary, prepaid, comprehensive medical-service plan. There are details in the bill which require amendment, but it contains most of the provisions which we regard as essential for the extension of medical care and the maintenance of high professional standards. Because its program provides for gradual development, it would not suddenly disrupt present methods of medical practice. Through encouragement of medical groups it would tend to improve and gradually transform medical practice by a progressive evolutionary process.

When the Congress enacted the Hospital Survey and Construction Act, those of us who were concerned with problems of medical care were encouraged to believe that the passage of this bill indicated that the Congress had adopted a procedure which it would next apply to the extension of medical care. This would have meant a similar survey of medical-care problems by each of the States with the financial and technical assistance of the Federal Government, for the purpose of uncovering the extent of existing deficiencies and determining the relative priorities for their successive correction.

We had hoped that the bill for medical care would contain grant-in-aid provisions similar to those of the Hospital Survey and Construction Act for the correction of the most serious deficiencies in medical care and that, as with the Hospital Act, a 10- or 20-year program would be adopted which would follow the priorities agreed upon by the State and Federal authorities. This seems to be the general philosophy underlying the Flanders-Ives bill (S. 1970) and, to some extent, the Taft-Smith-Donnell bill (S. 1581), and the Hill bill (S. 1456).

In view of the years of debate and endless hearings on this subject, we believe that the time has at last arrived for a nonpartisan measure which will accomplish the objectives for which we are striving. A nonpartisan Federal commission might be established for this purpose similar to the Hoover Commission or to the Goodenough or Beveridge Commissions in England. I should like to state that the New York Academy of Medicine stands ready to help in any way it can to such an end.

Senator MURRAY. The Flanders-Ives bill was filed here a very short time ago.

Dr. BAEHR. Yes.

Senator MURRAY. Do you not think that the conditions which existed in this country with reference to medical care presented a situation which should have made it important for the American medical profession to have taken an interest in it and to have made an effort to find out what the solution should be?

When we first filed legislation here some years ago, we were floundering around trying to find out what to do, and we were offering a voluntary system, but it was opposed. We got no cooperation, no help from anyone except criticism for not being able to present the correct solution, and of course it was a problem that was very difficult. It seems to me that in view of the conditions, we should have had better help on this matter right from the start.

Dr. BAEHR. I agree with you, Senator. Some of us have felt that way for a long time.

Senator MURRAY. I think you have always had a very progressive view of this situation, and I remember your previous testimony.

Dr. BAEHR. You will recall, Senator, that earlier this year a group of outstanding leaders in American medicine, 148, sent a protest to the American Medical Association on this subject, and I should like to make a supplementary statement in view of your remarks, that before coming here I consulted Dr. Hugh Morgan, professor of medicine, Vanderbilt University, Nashville, Tenn.; Dr. W. Barry Wood, professor of medicine, Washington University, and medical chief of Barnes Hospital, St. Louis, Mo.; Dr. H. F. Helmholz, chief of pediatrics, Mayo Clinic, Rochester, Minn.; Dr. Walter Bauer, associate professor of medicine, Harvard Medical School, and associate chief of medicine, Massachusetts General Hospital, Boston, Mass.; and Dr. Edwards A. Park, professor emeritus of pediatrics, Johns Hopkins Medical School, Baltimore, Md.

They are eminent members of the profession who earlier this year joined with me and more than 140 other physicians distinguished in the fields of clinical practice, medical education, and scientific research in a protest to the leaders of the American Medical Association in regard to its attitude on the extension of medical care. These men are in substantial accord with me on the views I have expressed this morning in regard to the health bills under consideration, especially S. 1970.

I feel sure that in expressing the opinion of the New York Academy of Medicine I am at the same time reflecting the views of a large number of the most important leaders in clinical and scientific medicine in this country.

I feel that the action of this group of men early this year had an important influence upon the American Medical Association which has already been reflected in the action of the officers and house of delegates.

We are very much encouraged by these actions, and we would like you to know that our disagreement with the American Medical Association—that is this group; I am not talking about the academy—does not alter the fact that we are united with them in believing that national compulsory medical insurance, this country is not ready for it at this time and will not be for some time, and we feel that from now on the American Medical Association will be prepared to sit down around a table, and we hope work out with other leaders in American medicine, leaders in nursing, education, and with the administration and people representing public health, a bill or a program which will be designed to meet the needs of the people of this country as rapidly as possible.

Senator MURRAY. Is your main reason for your feeling that a compulsory system would not work at the present time the fact that we would not be able to give the services?

Dr. BAEHR. Yes.

Senator MURRAY. Would not have the facilities?

Dr. BAEHR. Also the fact that we do not really know how to render services in return for contributory payments, not comprehensive services. We are doing an experiment along these lines, as you know, in New York.

We have at the present time in New York City under the health insurance plan of greater New York, a program which is giving comprehensive medical services, preventive and curative, to about 217,000 people, and we are doing it through medical groups, group practice units. We are assembling or we have been assembling in the last 2½ years that this program has been in operation a remarkable fund of usable information.

How many services are required by people when they can get unlimited services without deterrents? How much time of the doctors and the various specialists is required under modern medical services? What should their remuneration be? What educational standards should be required? There are hundreds upon hundreds of facts which will be revealed. Now it is that type of experience which we need both for voluntary as well as compulsory programs, and which we hope we can obtain under a bill which will permit experimentation, preferably on a voluntary basis.

Senator MURRAY. Did you find much evidence of malingering in the operation of this plan in New York?

Dr. BAEHR. No. There is some which you find among neurotics, but they have to be dealt with as they are dealt with in ordinary private practice, but they have not been a great burden.

Senator MURRAY. We have them now under regular practice.

Dr. BAEHR. Yes.

Senator MURRAY. You say that you would not be adverse to carrying out an experimentation with compulsory health in some particular area to find out how it would operate.

Dr. BAEHR. That is quite right.

Senator MURRAY. So you do not believe that the proposal is so outlandish that those who propose it should be called Socialists or Communists, do you?

Dr. BAEHR. No. We are only opposed to it because we do not think it will work at this time. We do not think you are ready for it; we think coming upon this Nation overnight it will breed medical abuses and interfere with medical education; will lower medical practice standards to such an extent that it will take a long time for this country to recover from it.

Senator MURRAY. Then you are in favor of all those provisions or parts, titles, of the Thomas bill except the one relating to compulsory insurance. The other ones are with reference to medical education, training of hospital personnel, research, and various other things.

Dr. BAEHR. Yes, in principle, but some amendments would be required.

Senator MURRAY. Oh, yes.

Dr. BAEHR. For example, in aid to medical education there is a great gap—whether $300 is right as a subsidy for a student.

Senator MURRAY. That is being given very careful study at the present time. The American Medical Association representatives and the representatives of the various medical schools have been sitting here with us. They came here first and testified and then they were invited to form a panel to sit with the expert advisers of the committee to aid us in working out the bill. You think that is a very proper procedure.

Dr. BAEHR. Yes.

Senator MURRAY. To have the advice and assistance of these men who really are equipped to give us the right kind of information and to protect us from making any mistakes in it.

Dr. BAEHR. That is the manner in which it must be done.

Senator MURRAY. Yes. I think probably you will find in the other titles of 1679, too, there may be some instances where some changes or corrections have to be made, but on the whole the bill is directed to the right ends except the part that you say is not practical.

Dr. BAEHR. Title VII.

Senator MURRAY. The compulsory system. And the reason that is not practical is because at the present moment we would not be able to give the services.

Of course, we were not planning on putting it into total operation immediately, but it was to be a gradual development rather than an immediate effort to supply all of the services and needs of the people. It would seem to me that if we put it into effect in that manner, we would be able to work out a satisfactory performance.

Dr. BAEHR. I doubt it, Senator. In many parts of the country only a fragment of the services would be available. They would be making their contribution exactly as would be those who are getting the complete service.

Furthermore our objection is equally strong to the fact that the bill as it is presently written were enacted and suddenly put into force throughout this country, would lead to very widespread medical abuses. I do not believe that that has been seriously enough appreciated.

Senator MURRAY. You say that—

> under a "fee for service" system of payment by an insurance fund, the pressure of subscribers for services and the financial rewards to the physicians for mere volume of services constitute a combination of influences difficult to resist.

You think that physicians would not be able to resist violating the program there because of that situation?

Dr. BAEHR. I am sure they could not resist. That has been the experience where it has been tried with voluntary plans in this country, and with compulsory plans on a fee-for-service basis outside this country.

Senator MURRAY. The medical societies are now operating voluntary plans, are they not, under which they have a fee-for-service practice?

Dr. BAEHR. But only for hospitalizable illnesses for the most part. There is very little service being given for any conditions that do not require hospitalization. There is up in Oregon and Washington a certain amount of comprehensive service given with some deterrents to curb the practice of overuse, but for the most part the plans which have been initiated and are operated by medical societies are for limited benefits only.

It results in people going into hospitals for many conditions that could be treated much more economically outside. On the other hand, for the most part operations, maternity benefits, and the hospitalizable medical conditions are predictable pretty well. We know how many there are and we know how many hospital beds there are. It is not subject to great abuse, and so that is actuarially sound, but they cannot move on from there to comprehensive coverage without changes in medical practice, as I have indicated in this statement.

Senator MURRAY. Doctor, I wish to thank you for your statement. If your associates wish to make any comments, we will be very glad to have them do so.

Dr. CRAIG. Thank you, Senator. I do not think there is any need for further comment.

Senator MURRAY. You are now succeeding to Dr. Baehr's position?

Dr. CRAIG. No. Dr. Watson is the president of the academy. Dr. Craig is the director of the academy.

Senator MURRAY. I am very glad to see you. Thank you for your statement.

The next witness will be James Brindle.

Mr. Brindle, you may proceed with your statement, giving your name and address and anything you wish to have in the record.

STATEMENT OF JAMES BRINDLE, CHAIRMAN, MEDICAL CARE COMMITTEE OF THE AMERICAN PUBLIC WELFARE ASSOCIATION

Mr. BRINDLE. My name is James Brindle. I am from Harrisburg, Pa., and am the director of the bureau of assistance in the Pennsylvania Department of Public Assistance.

I appear here today in my capacity as chairman of the medical-care committee of the America Public Welfare Association. This association is the national organization of local and State public-welfare departments and of local, State, and Federal welfare personnel; its membership includes administrators, board members, and workers from every State. Affiliated with the association are the two councils of State and local public-welfare administrators.

I would like to confine my testimony today to certain of the provisions of S. 1456, S. 1581, and S. 1106. My intention is to cover only the features of these bills with which public-welfare administrators and workers have had direct experience because of the fact that public-welfare agencies have for a long time been charged, in most States, with providing medical care to needy persons.

I am not authorized to testify on S. 1679. This measure has not been studied by our medical-care committee. In this connection, it appears to me that there is little comparability between the health-insurance features of this bill and the provisions of the proposed legislation affecting medical care for low-income families that I wish to discuss. However, there is under consideration by the Ways and Means Committee of the House a measure that could be considered an alternative to S. 1456 and S. 1581, and which has the endorsement of my association. This bill is H. R. 2892, which revises the Social Security Act to include another category of public assistance—general assistance. It would provide, therefore, for Federal participation in assistance granted to all needy persons, and the standards of need applied under that bill would not have to be similar to those applied for granting of total assistance.

This bill would also remove the present restrictions around Federal participation in the costs of medical care to the needy. Now, only payments made directly to the recipient can be matched by the Federal agency. H. R. 2892 would extent Federal aid to States for payments direct to practitioners, institutions, insurance plans, and other organizations for medical services furnished recipients.

Incidentally, this bill would also include additional financial provisions for States, and States now under welfare plans find it impossible to adequately finance medical care. The expenditures last year ran something over $100,000,000 from State and local funds, and the abysmally low standards applied in some of these welfare medical plans point pretty clearly to the need for Federal help in this area.

Both S. 1456 and S. 1581 would provide Federal financial aid to States on a matching basis for medical care to low-income groups. They involve the administration of a means test—determination of whether, on an economic basis, individuals and families are entitled to such governmental aid. This means that the programs envisaged by this proposed legislation are actually in the field of public assistance, regardless of how or by what agency they are administered.

Public assistance is a function of government in which there exists fairly long experience with joint Federal-State-local relationships. Its expenditures are controlled by the States in relation to appropriations made available by legislative bodies. The means test, which is universally applied, is made more or less restrictive in relation to State and local appropriations. Fairness and equitability are prime objectives in the administration of this measurement of need. Benefits, too, vary with the money available. Administration in this field of government assumes the dual role of assuring protection to the interest of the applicant and recipient of assistance and to the interest of the whole public—the taxpayers. In the early thirties there was an attempt to turn over to nongovernmental agencies large sums of public money to be distributed to needy persons. It didn't work. Experience has proven that agencies of government, directly responsible to elected legislative bodies, must administer public assistance and control expenditures for this purpose. This is now an accepted principle of public-welfare administration.

These two bills, S. 1456 and S. 1581, violate this principle because they would let private agencies assume a large share in determining how public money should be spent.

Incidentally, the other bill which came under consideration I believe after I prepared this, that is the Flanders-Ives bill, S. 1970, would also either make very difficult Government control in the area of expenditure, or would pass over some areas of what we consider properly to be Government control, to a private agency which is not responsible to the legislature or to the Executive.

In S. 1456 private organizations like Blue Cross and Blue Shield could furnish to eligible persons, at their own discretion, any amount of service and then bill the public agency. This bill does not provide for the payment of premiums of nonprofit voluntary hospital and hospital medical service insurance plans, but rather provides that the actual costs of services furnished persons certified as eligible on the basis of need be passed on from the insurance fund to a public agency.

I think a good bit of the newspaper publicity on 1456 indicated that this bill would merely pay premiums, but the provisions of the bill itself constitute a much broader and more expensive grant.

Obviously, the lowest income groups, including assistance recipients, are a poor risk, insurance-wise, and could hardly be included with less adversely selected groups at anything near normal premium rates. The cost, therefore, is hard, if not impossible to estimate. What if State appropriations were not available to pay the bills? Federal funds only match—they don't make up State deficits. Who would say, and how would he determine, whose bills would be honored? whose arbitrarily reduced? whose sent back marked "Not sufficient funds"? How disposed would a Blue Cross organization be to continue with the plan the year after the public agency had said, "Sorry, we haven't any money left"? What is actually gained by interposing a third party between the public agency paying the bill and the hospital furnishing the service?

S. 1456 makes it mandatory that control of expenditures pass from Government to private agencies. S. 1581 makes it possible. Neither meets the well-established criterion that public funds should be publicly administered and controlled, for the protection of the taxpayer and the beneficiary. Neither provides for a system of standards and controls that would enable the responsible administrator at the Federal, State, or local level to carry out his duty to assure proper administration, and to assure fair treatment to the recipient.

S. 1456 provides for administration at the Federal level by the Public Health Service. The Surgeon General is designated as Administrator. S. 1581 would create a new Federal agency—the National Health Agency—whose Office of Medical, Dental, and Hospital Services would be headed by a doctor of medicine, licensed to practice in one or more States. A council, provided for in both bills, would have the power to overrule these responsible Government agents. From our experience in the public-welfare field, we believe that such authority—vested in a board comprised of persons not responsible directly to the executive or legislative branches of Government, and with majorities representing those furnishing the services—should not be permitted to exercise such controlling authority over administrators who are not only responsible for, but often accountable for public moneys.

On this point of organization, too, I have another comment to make. The association which I represent has long advocated combined over-all direction at the Federal level of health and welfare programs. Since Federal functions in these fields, unlike those at the State and local level, are not operational but involve, rather, planning, policy formulation, and administration of grants-in-aid to the States, we feel that there is every advantage in keeping them in one over-all department in order to facilitate the working out of delicate, evolutionary relationships. We therefore favor Federal administration of medical-care programs for low-income groups under the same general auspices as assistance programs. Presently this is the Federal Security Agency. Hopefully it will ultimately be advanced to departmental status.

At the local and State level, both health and welfare agencies are involved. Cooperative relationships have been worked out between them in many States. But any universal, long-time subdivision of tasks to be performed at the operating level for programs like those outlined in S. 1456 and S. 1581 should not yet be finally determined.

Legislation to provide medical care for the needy should, therefore, allow States to work out the best relationships between health and welfare departments in terms of their own situation—at State option. Legislation should not force a State health department, not ready to shoulder such responsibility, into the administration of a program with which it has had no practical experience.

This is related to another factor on which I touched earlier: the means test. It is the considered opinion of the association that the administration of the means test be by a public assistance agency for the present. Public assistance is administered on a Nation-wide basis. It would appear uneconomical to duplicate these existing facilities for the determination of need which operate now in every locality in the Nation. The expenditures under any needs program are very delicately affected by regulations which define when a person or a family needs assistance—in money or in medical care. I am not saying that the means test is a rigid thing. As a matter of fact it is extremely flexible, and can be adjusted to the availability of money. It can be liberal or strict. But it requires skill and experience to administer. Unfortunately people who have not worked with this instrument over a long period of time seem to believe that it is a very simple tool. Only experience discloses its difficulties. Progress has been made by public assistance agencies toward formulating objective, equitable, and more simple criteria for determining need; but the degree of technical skill required to measure and meet economic need in a way that does not contribute to the dependency of the beneficiary, or result in injustices, is still too great to enable health agencies, generally to administer such processes properly.

In Pennsylvania we were charged by the legislature in 1947 with providing medical care for needy children to correct conditions disclosed by school health examinations. Planning and administration of the program are, by law, allocated jointly to the health, public instruction, and public assistance departments. The law provides that the department of public assistance determine need. Two years' experience has demonstrated the wisdom of this provision. School nurses have learned that objective criteria are needed to find out if a family should be expected to pay for its own medical care; they used to think that such a determination could be made on a "hunch." The means test applied in Pennsylvania's school medical assistance program was designed with emphasis on equitability, simplicity and definiteness. It differs somewhat from the rules of eligibility for determining eligibility for assistance grants. Education and health administrators have indicated that they are now more convinced than ever that determination of economic need is a specialized job which should remain in the hands of the department of public assistance.

The scope of a medical care program is another important point to consider. S. 1456 is designed to provide hospital in- and out-patient care only. This would place a premium on hospital care as opposed to medical care in the home or the practitioner's office. Since hospital care is most expensive, this scheme would be unduly costly. It would discourage the highly individualized plans which public assistance agencies encourage persons to make to provide care in the patient's home, to secure nursing or housekeeping service in lieu of institutional care, and to resort to many other less costly alternatives.

This bill would not be adaptable to the provisions of care for the chronically ill—particularly the very numerous aged chronically ill—for whom welfare agencies are particularly concerned. In Oregon, for instance, 40 percent of medical-care assistance expenditures go for nursing-home care. S. 1456 would help assistance agencies only to pay for hospital services, which is the item of medical care which is administratively easiest to handle under present plans. The medical care program needs to be a balanced program, and, in view of limited facilities, extremely broad and flexible.

I referred earlier to the fact that H. R. 2982 might be considered as an alternative to S. 1456 and S. 1581. The desirability of so considering this proposed House legislation is emphasized by the fact that it would utilize the existing public-assistance system for the administration of medical care to the needy. This system provides adequate protection to the taxpayer in the form of a system for formulating standards, assuring supervision and relating benefits and the level of eligibility to the amount of money available. It also affords protection to the beneficiary through standard setting, supervision of the quality of care, the right of the beneficiary denied aid to appeal to the State agency, and confidentiality of private information.

There is another bill on which I would like to comment. It is S. 1106 which provides for 50-50 matching grants from the United States Public Health Service to State departments of health for certain medical services and medicines that are standardized in their nature but so costly as not to be generally available. This legislation would probably not involve serious problems of administration or policy for welfare departments. This would be especially true if no means test were involved, which seems to be a possibility under the proposed law. Welfare agencies could look to health agencies to provide these special, more costly services and drugs, which would be a resource on which welfare agency clients could draw. Since many State health departments now furnish specialized services and medicines, no new problems would be posed by the passage of this bill.

I realize that most of my comments on this legislation have been rather negative. I'd like to say that the association also recognizes that these bills incorporate many features, contained in other pending bills, which we strongly favor. The provision for merit systems of personnel administration, for Federal aid in proportion to the financial ability of States, further expansion of Federal aid in hospital construction, aid to increase health service manpower, and help in the development of local public health units are in general favored by welfare agencies and administrators.

I want to make it clear that we are also entirely sympathetic with the intent in these bills to remove any possible stigma from the recipient of public aid for medical care. We doubt, however, that this can be achieved simply by turning administration over to private agencies or health departments or by attempting to conceal the identity of recipients.

Any administering agency will be confronted by the same problem so long as the setting remains one involving the certification of need, setting special fee schedules, checking on the services provided, and other controls necessary to assure economy in cost and adequacy of service. We feel, however, that the sponsors of these bills have performed a real service in calling attention to this basic problem.

I am grateful for the opportunity to pass on to this committee the comments of the American Public Welfare Association on these very important medical care legislative proposals. I hope that the organization will have been helpful in developing Federal aid programs that will enable needy persons to secure more adequate medical care.

Senator MURRAY. Thank you very much for your statement.

The next witness is Jerry Voorhis.

STATEMENT OF JERRY VOORHIS, SECRETARY, COOPERATIVE HEALTH FEDERATION OF AMERICA; ACCOMPANIED BY MELVIN DOLLAR, DIRECTOR, GROUP HEALTH ASSOCIATION, WASHINGTON, D. C.

Mr. VOORHIS. Good morning, Senator. Mr. Chairman, if I may, I would like to ask Melvin Dollar, the director of Group Health Association of Washington, to come up here with me. He is the Washington representative of the Cooperative Health Federation which I am here to testify for.

Senator MURRAY. He may do so.

Mr. VOORHIS. I think there may be some points on which Mr. Dollar will be much more valuable than myself.

Senator MURRAY. We are very glad to have you here this morning with us. I am sorry that we do not have a full attendance of the committee, to hear your testimony. But we are all tied up in other hearings and meetings, so it is difficult for everyone to be here.

Mr. VOORHIS. I know a little bit about that, Senator Murray.

Senator MURRAY. I have to leave myself in a few minutes to go to a caucus in Senator Lucas' room with reference to the pending Taft-Hartley bill. I have heard your testimony before, and I am in full accord with your views on this subject, so it would not make much difference whether I heard it or not again, but I think you might have some new suggestions, and I want to assure you that we are very glad to have you here.

Mr. VOORHIS. Thank you very much, sir.

Mr. Chairman. I would like to say that I know this committee has been holding hearings on this subject for many weeks, and therefore what I would like to do with my testimony which has been furnished the committee in quantity, is read my last paragraph and then I would like to go through the testimony and just hit the high points, if that is all right, with the understanding that the whole testimony can be printed in the record.

Senator MURRAY. Yes, the complete statement will be printed in the record.

(The statement referred to is as follows:)

STATEMENT OF JERRY VOORHIS, SECRETARY OF COOPERATIVE HEALTH FEDERATION OF AMERICA

Not so very long ago, as time is reckoned, the education of children was regarded as an individual family affair. Gradually it was recognized that an informed citizenry is essential to a successful democracy. And a system of free public schools was built up in our country.

Children, however, have never been required to attend public schools. Some school, we say, they must attend, but if their parents belong to a group which sees fit to establish parochial or other types of private schools, then that is all right. And we know that our public schools are better for the fact that private schools exist side by side with them.

It was not until the great depression of 1929 that this Nation recognized in any practical way that unemployment constitutes a problem of national concern rather than the hard luck of individual families whose bread-winners are laid off.

We have been even more slow in recognizing the general health of the people as a matter of concern of the Nation as a whole. Indeed it took World War II with the whole idea of "total war" involved in it to bring about this recognition.

Today, however, there is little dispute about the major point. Everyone agrees that the health of the Nation as a whole is the deep concern of the Nation as a whole. Difference of opinion arises as to how to carry that concern into practical action. But our whole system of public health services, the office of the Surgeon General, the existence of dozens of private organizations for the promotion of health, the vast sums donated to various foundations working in the health field, the organization of group health plans by doctors and consumers alike, and above all consideration of legislation by the Congress—all these demonstrate the fact that we now recognize the existence of a national problem in the health field and propose in one way or another to solve it.

The only reason we are here today testifying on behalf of the Cooperative Health Federation of America is because that organization is concerned with the total economic problem connected with adequate health care for the people. If we were concerned only for the advancement of our cooperative plans we would not be here. But like any conscientious group of citizens our first and primary desire is to see the problem solved. Our second desire is to help solve it in the manner in which we believe, out of our experience, it can be solved best.

We are encouraged to note certain marked advances that have been made over the past couple of decades.

The most important one has been the advance of medical science itself. The medical profession in the United States has today the knowledge and skill which could render this Nation one of almost generally healthy human beings—if only that knowledge and skill could be brought to bear in the right places at the right times and in sufficient amounts. And let me say at this point with all the emphasis I can muster that those consumers of health care for whom I am privileged to speak would be the very last ones in the whole country to suggest that any layman presume to control the practice of medicine or dictate to the physician how he shall treat his patients. The one person we cannot get along without if the health problem of the Nation is to be solved is the doctor.

The medical profession itself has done much to try to bring the benefits of modern medical science to more people. But in all too many cases this has been a charity proposition and the doctors have not been paid for their services. This is one of the situations we believe should be changed.

Other progress, however, has been made beside purely scientific progress. It can be termed progress in the organization of medical care or in the economic aspects of medical care.

The old idea—which still persists in some quarters I am afraid—was that all the people and all the doctors would depend for the existence of facilities and the support of the profession upon their being enough well-to-do sick people in each community. This idea just doesn't work, partly because there are not enough well-to-do people, partly because the ones there are don't get sick often enough.

We have discovered that millions of people once written off by their fellow citizens as lazy, worthless folk have simply been sick. We have discovered that they have been sick of preventable diseases. We found that all too many of the men called in the draft and found unfit for service were disabled by entirely preventable maladies. A lot has been found out about the relationship of absenteeism in industry and preventable sickness. And in most cases the reason why all these illnesses have not been prevented has been basically economic. People just couldn't afford to pay for adequate care after they were sick. So, in many cases they didn't pay at all. Out of all this has come a realization of the vast importance of preventive health care.

And one of the main reasons we are here is to tell the committee something its members already know—namely that the only way in which people can be induced to use preventive medical care is when they have prepaid its cost and when they know they have done so. That is reason No. 1 why we believe so earnestly that the best single solution to the problem of health economics, insofar as the people are willing and able to effectively apply it, is the cooperative group health service plan where the people consciously prepay the cost of comprehensive medical care.

In the second place we have discovered in the past few years that an alarming percentage of the families of the United States are not able, within their incomes to pay, out of pocket, costs of medical care in times of need. Especially are they unable to meet the costs of catastrophic illiness when, without warning, is strikes. On all sides it is agreed that the basic answer to this purely economic problem lies in group prepayment. Whereas individual families cannot pay the doctor and the hospital at the moment of their great need of them, whole groups of families can pay on regualr monthly schedules the amount of the average cost of care for the group as a whole.

This is reason No. 2 for cooperative group action. It is the one way in which most people can and will pay for adequate health care.

In the third place there has been a great increase in specialization in recent years. But specialists can only afford to practice under conditions where they are reasonably assured that the number of patients needing their particular type of care will be sufficient. Specialists have not and never will replace the general practitioner. But more and more it is becoming obvious that if our peoples' health needs are to be adequately met both are needed. The only way whereby such an arrangement becomes practical is where a considerable group of potential patients are joined together to prepay the cost of comprehensive care. For in such cases group practice becomes feasible—even in rural communities where the present need is so very great.

This is reason No. 3 why we are working so hard to advance cooperation and group health plans, and why we urge that Congress do nothing to discourage them.

The fourth fact that we have learned in the past few years is that both doctors and health facilities are very badly distributed indeed as between different areas of the country and different groups in the population. Not only are there far too few doctors and far too few health facilities over-all for the needs of the Nartion. But those we do have are much too concentrated in the larger cities and even in the more prosperous areas of those cities. For example, in 1906 Kansas had a population of 1,544,000 people. It had 2,732 physicians. In 1940 Kansas had a population of 1,900,000 but there were only 1,900 physicians in the State. Furthermore in 1906, 50 percent of Kansas physicians were practicing in communities of 1,500 or less, while in 1942 only 25 percent were in those smaller communities.

Everyone knows that one corrective that is needed is better facilities in the areas of severe health-care shortage. That is why the Hill-Burton Act was passed. More, we fervently believe, needs doing along that same line. And we are convinced, too, that only when the people of the so-called shortage areas join together and organize their common need in group health cooperative plans will a solid base be laid for retaining the services of able physicians in those areas.

This is reason No. 4 for our fundamental position which is that the first attainable and concrete step forward in the solution of the health problem of America would be the inclusion of as many people as possible in prepayment, cooperative plans providing comprehensive care and the advantages of group practice.

The Cooperative Health Federation includes in its membership various types of organizations—all with a common purpose. The groups that can most readily provide themselves with prepayment health-care plans are those already organized for some other purpose. Some of the most successful plans therefore are among members of labor unions, farm organizations, or church parishes. But others are cooperatives organized for the specific purpose of enabling their members to afford adequate health care. Some of our member organizations provide complete care to their subscribing member families. Others are insurance plans.

But as I said in the beginning our first concern is not for our approach to the problem. It is for the solution of the problem itself. And we are driven to admit that the following facts are true: (1) that millions of families cannot out of their present incomes afford, even on a prepayment basis, adequate medical care; (2) that the progress of voluntary plans is necessarily somewhat slow if they are to be soundly put together and that therefore many millions of people will not be included in them for some time to come; (3) that there are barriers of legislation and discrimination which have been erected that prevent the very organization, let alone the growth of voluntary consumer-sponsored plans; (4) that there are income disparties as between whole geographical areas with which voluntary plans alone can hardly be expected to successfully cope unless sound and well-conceived measures of assistance to low-income areas are put into effect.

For these reasons the last annual meeting of the Cooperative Health Federation of America passed the following resolution:

"Whereas the Cooperative Health Federation of America has gone on record as favoring the principle of national health insurance provided that voluntary, direct service plans are promoted, encouraged and protected; and

"Whereas the President has stated that such a program would be placed before the next Congress: Therefore, be it

"*Resolved*, That the officers of the Cooperative Health Federation of America consult forthwith the cooperative, farm, labor, and other consumer organizations for the purpose of uniting views on essential elements of a national health insurance program that relate to the promotion, encouragement, and protection of voluntary, direct service plans and promote the adoption by the administration and the Congress of these views and the program."

That resolution was not lightly passed. In fact I must add that some of the member organizations of the Cooperative Health Federation of America, notably the Health Insurance Plan of Greater New York, have never taken a position on compulsory health insurance, and in all probability, will not do so. Some of our member organizations would underline the principle supported in the above resolution; others would underline the reservations. But the annual meeting did pass it in the form I have just read.

Moreover we recognize fully that unless other titles of the omnibus bill before the committee, or other bills providing similarly, are passed national health insurance in itself would operate under critical handicaps. The training of additional physicians, the construction of additional facilities are but two of what would appear to be prime requisites. So is the readiness of the medical profession to cooperate in any program that may be begun.

We do not believe that national health insurance need lead to "socialized medicine" any more than the payment of an old-age pension leads to socialization of grocery stores where the pension checks are largely spent. But we do recognize that unless there exists a vigorous pattern of voluntary action along with health insurance there might be serious dangers involved. We are concerned to guard not only the physical health of people but the health of our democratic society as well. We don't want people to lose sense of responsibility. And we are convinced they need not.

The burden of this testimony can be summed up as follows. First, our country has come to the place where there must be a means of guarding, preserving, and improving the general health of the Nation; but second, we must find ways to acocmplish that purpose which will develop rather than weaken the sense of responsibility and the initiative of the people, both lay and professional, and which will therefore promote democratic values in our society.

So, going back to the illustration I gave of the schools of the country, both public and private, we believe compulsory health insurance will fail in achieving what its proponents hope for, if it becomes law and is not accompanied by the growth all over the Nation of voluntary plans of a variety of kinds. We believe experimentation is the very life of any democratic nation. We believe that doctor-sponsored voluntary plans should be encouraged. We certainly believe consumer-sponsored voluntary plans should be. A national insurance plan cannot in and of itself assure the people more medical care of better quality for the dollar they spend. Such a plan will give millions of families money to spend for health care which they greatly need. But their problem will remain unsolved unless throughout the Nation voluntary group plans enable those very people to prepay the cost of comprehensive care on a group practice basis.

Furthermore unless voluntary plans are encouraged we will lack yardsticks which are so very essential in any situation where a problem is attacked in its over-all aspect by broad sweeping measures. Voluntary plans must always be available as yardsticks of the quality of health care which people can have when they will take the trouble to act together under their own initiative. And, I must add, to perform such a yardstick function the voluntary plans must not be under any sort of outside control nor part of any great system. They must be free; they must really be locally controlled; they must be in a position to experiment in better economic and organizational methods; and there must be no artificial or monopolistic barriers against their growth.

This is why the Cooperative Health Federation would insist upon the retention in any legislation of certain provisions now in title VII of S. 1679 which are essential to the protection of voluntary prepayment plans. Those provisions are:

Section 703 (particularly the following language):

"Every individual eligible for personal health services available under this title may freely select his physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: *Provided*, That the practitioner, medical group, hospital, or other person has agreed under part C to furnish the class of services required and consents to furnish such services to the individual."

Section 716 (particularly (a) and (b) which read as follows:)

"(a) In the provision of personal health services, it shall be the policy to utilize individuals or organizations qualified under this part to render such services, including (1) any organized group of individuals, (2) any partnership, association, or consumer cooperative, (3) any hospital or any hospital and its staff, or (4) any organization operating a voluntary health-service insurance plan or other voluntary health service plan.

"(b) The State agency is authorized to enter into an agreement with any organization referred to in subsection (a) for the provision of personal health services under this title. Any such organization, whether or not it enters into an agreement with the State agency on its own behalf, shall be permitted to act as agent for individuals or other persons in negotiating or in carrying out agreements with the State agency for rendering personal health services under this title."

Section 717 (c):

"(c) No agreement made under this part shall confer upon any individual or other person, or any group or other organization, the right of furnishing or providing personal health services as benefits, to the exclusion in whole or in part of other individuals, persons, groups, or organizations qualified to furnish or provide such services."

Section 718 (particularly the following language):

"(a) Agreements for the furnishing of medical or dental services (other than specialist services) as benefits under this title shall provide for payment—

"(1) on the basis of fees for services rendered as benefits, according to a fee schedule;

"(2) on a per capita basis, the amount being according to the number of individuals eligible for benefits who are on the practitioner's list;

"(3) on a salary basis, whole time or part time; or

"(4) on such combinations or modifications of these bases, including separate provision for travel and related expenses, as may be approved by the State agency."

"(c) Any of the methods of making payments from among the methods listed in subsection (a) or subsection (b) may be used in making payments to groups of practitioners or organizations or other agencies which undertake to provide specialist services as well as general medical or general dental services."

But further to encourage voluntary action by the people the Cooperative Health Federation has proposed certain amendments to the legislation before this committee and made its support conditional upon their inclusion in any bill that might be brought to the floor of Congress for action.

The first of these amendments is as follows: Section 742 describes State plans of operation which, the bill says, will, if put into operation, make States eligible to administer health insurance. Our amendment proposes to add a ninth feature to any such State plan by adding after subparagraph (8) the following:

(9) "Provides for the right of any nonprofit association or consumer cooperative as named in section 716 to contract with physicians, on a mutually satisfactory basis, for the furnishing of services to their members."

This amendment has been introduced by Senator Humphrey.

S. 1679 as now drafted contains eight prerequisites in this section to be fulfilled by the State, before administrative functions will be delegated to the State. This amendment, subdivision (9), adds another prerequisite.

In almost all of the States there is a common-law prohibition against so-called corporate practice of medicine. This rule is based upon decisions holding that the selling of a physician's services by a corporation is contrary to the physicians' licensing laws and public policy because it opens the doors to commercial exploitation of medicine. While this prohibition should not apply to cooperative and nonprofit plans, as explained later, yet attorneys general and private attorneys in many States feel that it does or might apply and thus the prohibition is an effective bar to, or at least a cloud over, consumer-sponsored plans.

In addition to this common-law prohibition, there are restrictive laws in many of the States sought and obtained by medical associations giving them alone the permission to operate voluntary repayment plans.

These prohibitions and enabling acts are holding back the development of consumer-sponsored plans in many of the States. Thus, without the proposed subsection (9) amending section 742 (a), the other sections of S. 1679 permitting agency agreements with hospitals and voluntary health organizations, namely sections 715 and 716, are almost meaningless so far as consumer-sponsored plans are concerned.

The States have exclusive sovereignty over matters pertaining to public health and safety within their borders. However, the Federal Government may require certain prerequisites such as now contained in section 742 (a) to the delegating of administrative function of health insurance to the States. It is a reasonable and sensible request that the amendment proposed as subsection (9) be included in order to effectively carry out the purposes of the bill, especially in sections 715 and 716.

As the bill now stands, in order to delegate administrative functions to the State, some State legislative action is necessary, either by way of an enabling act or by resolution authorizing the executive to make an agreement with the Federal agency. The inclusion of our subdivision (9), in our opinion, should not create any controversy in the State legislature. After all, this subdivision merely gives to a nonprofit association or consumer cooperatives the right to ask the State agency for an agreement under section 716.

As to contracts with physicians, there is no dictation as to their form and as stated they must be on a "mutually satisfactory basis". The members in the association are free to join or not and the physiicans are free to participate in the plan or not. So long as the arrangement is voluntary on all sides, we cannot see how there could be an objection to the inclusion of this additional prerequisite.

It is true that when the State enabling act under section 742 (a) is passed it will remove the prohibition against so-called corporate practice of medicine as it might be applied to nonprofit associations or consumer cooperatives. In this there is no abrogation of the purpose for the prohibition because (1) the association or the consumer cooperative and its membership are for all practical purposes one and the same, and it could not be said that there is a third-party corporation intervening, and (2) the association or cooperative, being nonprofit, it cannot be said that there is any commercial exploitation of medicine. In other words, there is a clear distinction between these types of nonprofit organizations and those types which exploited medicine and gave rise to the State supreme-court decisions which laid down the rule against corporate practice of medicine.

Consumer-sponsored voluntary plans, through their experience, have shown that they strive to achieve comprehensive health care, preventative medicine, and group medical practice, all of which are very desirable by way of bringing more and better medicine to the people. In rural areas especially, where there is a shortage of physicians, permission to rural communities for organizing to set up modern medical workshops and a pool of funds to assume adequate income to physicians, is the best means in our experience for inducting doctors to settle in rural areas and thus effect a better distribution of medical care. The people in rural communities we know will not organize for this useful purpose if there is a cloud over their right to make contracts with physicians. If S. 1679 should pass without this proposed amendment, we could expect the same difficulties as have been experienced in some other countries, where the superimposition of health insurance upon the existing system of distributing medical care and without the benefit of local community organization has given rise to serious administrative problems and give little impetus to the improvement of quality of service. In New Zealand, for example, 10 years of experience with universal health insurance shows that there has been an actual increase of the movement of physicians from rural to urban areas because there the physicians have better facilities and are able to see more people in a day and thus able to make more income. We believe there must be proper inducement for the organization of the consumers of medical services on the local level. Hence our strong insistence upon our amendment as a simple means of opening the door for the organization of vitality needed voluntary plans.

Neither the medical societies nor our federation can claim to have the blueprint for the best type of local plan. This is a matter for public acceptance.

Thus there should be freedom of opportunity to develop local plans, by whatever sponsorship, and the equal right of any plan to ask for an agreement with the agency under section 716. Needless to say, the State agency will determine proper standards and will effect agreements with those best able to render good medicine.

We insist that whatever is done about over-all national legislation, including national health insurance, the people should have the right to organize a local plan which will bring the doctors to the people, will bring the people modern medicine through group medical practice, and will bring health conservation programs and comprehensive service.

This right can be assured only by the inclusion in any legislation of language such as we propose.

Now I would like to say at this point that for the past year, ever since the National Health Assembly was held here in Washington in May 1948, a series of joint meetings has been going on between the Council on Medical Service of the American Medical Association on the one hand and representatives of labor, farm, and cooperative organizations—that is, the consumers of medical care—on the other. These meetings were the result of a resolution unanimously adopted by the medical-care section of the National Health Assembly. (Dr. James McVay, chairman of the AMA Council, has been chairman of the AMA group, and I have had the honor to be chairman of the committee representing the organizations of consumers of medical care.)

Well, the purpose of these meetings has been to iron out misunderstandings of which there were a good many on both sides and to try to develop means of cooperation in the advancement of voluntary plans, including lay-sponsored plans. We hoped to secure joint action with the AMA in getting State enabling legislation for the organization of voluntary health plans and in eliminating discrimination against doctors participating in lay-sponsored plans. Finally, we wanted AMA to give us a set of standards to be applied to the operations of cooperative plans on the basis of which they could gain a seal of approval from organized medicine.

I want to say that on both sides these meetings have been conducted with a sincere desire to reach agreement. Further, we did agree in our joint committee upon a set of standards and the Council on Medical Service did succeed in securing their adoption by the recent Atlantic City meeting of the AMA. By this result, we are encouraged. But the house of delegates of the AMA passed the standards not as grounds for approval by the AMA as we had hoped, but only as a sort of guide to State and local medical societies by which any accrediting must be done of the voluntary plans. So we have to wait and see how much has been accomplished. For we know that, whereas in some States the medical societies will deal without prejudice, there are other States and counties where the most bitter opposition to and misunderstanding persists. The question is whether the medical societies in this latter group will in good faith carry out the action proposed by the House of Delegates.

All this seems to us to strengthen the arguments for the amendment just outlined. We think some provision of this sort should go into any legislation that might be passed. For we believe the right of the people to act voluntarily in attempting to solve their own problems should be basic to all American law. And we believe that the recent action of the house of delegates of the AMA is at the very least indicative of a trend within that organization favorable to removal of artificial barriers now existing against cooperative health plans organized by the people. Obviously, however, we cannot relax our effort until these barriers have in fact been removed.

Our second proposed amendment is directed to the same end—namely, the encouragement of voluntary action by the people on their own behalf. This amendment, to be inserted at the appropriate place in the bill, presumably in title III, was originally drafted to read as follows:

"In order to assist the States in providing needed health facilities, and equipment, not limited to hospitals, there are hereby appropriated for the fiscal year ending June 30, 1950, the sum of $ ——— and for each of the 10 succeeding fiscal years the sum of $ ———. The sums appropriated pursuant to this section shall be used for making payments to States which have submitted, and had approved by the Surgeon General, State plans for construction of clinic, health center, or hospital facilities, or any combination of such facilities, and the equipping thereof. The sums appropriated shall be used only for loans to nonprofit organizations which will operate a comprehensive personal health-service plan, including group medical practice and a health-conservation program. Such loans may cover the full cost of the facility and equipment and extend over a period of 50 years, with interest not to exceed 2 percent per annum."

In rural areas, especially, we sorely need clinic and health-center facilities.

The great problem in rural areas particularly is the lack of modern medical workshops of the type which would attract physicians whose modern training makes such a facility an absolute necessity. Most rural communities would not be able to sustain a hospital, but would be able to sustain a smaller facility capable of rendering day-to-day medical care and emergency treatment. Experts in the field of rural health agree that the most sensible way to bring doctors to the people is to have a general hospital located in the natural trade center, with outpost clinics and health centers branching out into the smaller surrounding communities. With this system, two important things can be accomplished: (1) The physicians in the local health center, together with the specialists in the general hospital, are available to provide most or all of the types of treatment needed. The physicians in the local clinic and in the diagnostic center would have full opportunity to collaborate and bring to the people the best in modern diagnosis and techniques of treatment, and (2) the people would have immediately available near their homes and farms general and emergency care, which would provide for the greatest part of their needs; and for chronic or difficult cases they would have the services of the diagnostic center and general hospital, all included in the same prepayment cost.

We know from our experience that the people in most rural areas would be able to sustain such a local facility, even though it required augmentation, by monthly dues, of the amount which would be allotted under the contract with the agency pursuant to section 716. However, the great difficulty is finding the original capital to build the facility.

We are asking in our proposed amendment for long-term loans such as are now being made in the Rural Electrification Administration.

It will be noted that our proposed amendment limits the loans to "nonprofit organizations which will operate a comprehensive personal health-service plan, including group medical practice and a health-conservation program." We feel that these loans should be thus limited in order to stimulate the development of the type of plans which will deliver the best type of medical care to the people.

The greatest impelling reason for our proposed amendment is that it would act as an inducement for communities to organize plans, especially in rural areas, in order to work out a better distribution of our available medical personnel. Without this amendment, we are fearful that S. 1679 as it now stands would not effect a better distribution of medical care as an inadvertent byproduct and that there would be little, if any, inducement for smaller communities to attempt the accumulation of sufficient capital to construct health centers. Some financial assistance is necessary.

We recognize, however, that in some rural areas there simply are not sufficient financial resources to carry such loans as we propose. In such cases we believe grants should be made available not only for hospitals but also for clinics and health centers, if the local people show they are prepared to sustain a worth-while and needed plan.

It should be pointed out, too, that it is also highly desirable for industrial workers to obtain such loans in order to establish facilities which will provide them with group medical practice and health-conservation programs, neither of which would be expected to result automatically in an insurance program, without some inducement for organizing a plan to provide modern medicine by such means.

We believe that, regardless of what may be done with respect to other legislation, the substance of our proposed second amendment should be enacted into law by this Congress. We are most glad, therefore, to be able to point to an outstanding bill (S. 1805), introduced by Senator Humphrey and wholeheartedly supported by the Cooperative Health Federation of America and its affiliated organizations.

The text of that bill reads as follows:

"A BILL To authorize grants and loans to cooperatives and nonprofit associations, operating medical- and hospital-care plans, for the acquisition, construction, and equipment of needed facilities

"*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That this Act may be cited as the 'Cooperative Health Act.'

"Sec. 2. The purpose of this Act is to assist cooperatives and nonprofit associations to initiate and carry out voluntary, prepaid medical-care plans for their members by grants and loans for the acquisition, construction, and equipping of the necessary facilities.

"Sec. 3. There is hereby authorized to be appropriated for the fiscal year ending June 30, 1950, and for each of the four succeeding fiscal years, the sum of $25,000,000 to carry out the purposes of this Act. Grants or loans for part or all of the cost of acquisition, construction, and equipping of the physical facility may be made to a cooperative or nonprofit association which provides—

"(a) sufficient regular payments from its members for purposes of financing the cost of providing themselves with medical care and of maintaining the facility;

"(b) one vote per member and democratic choice in selection of the governing body, provided that not more than one-third of the members of such body may be composed of physicians furnishing the medical care;

"(c) in its arrangements or agreements with physicians that there shall be no interference by the lay management in the practice of medicine and that the method of compensation to physicians shall be on a mutually agreeable basis;

"(d) that so far as practicable, having regard for size of the facility and the membership being served and other relevant factors, the plan shall provide for preventive as well as curative care, group practice, and comprehensive medical care;

"(e) that participation in the plan by member-patients and by physicians shall be voluntary.

"Sec. 4. To be eligible for a grant or loan, or a combination of both, the cooperative or nonprofit association shall submit an application to the Surgeon General containing such information and assurances as he deems necessary and an agreement to make such reports, in such form and containing such information, as the Surgeon General may from time to time require, and to comply with such provisions as he may from time to time find necessary to assure correctness and verification of such reports.

"Sec. 5. The Surgeon General shall formulate standards for the making of grants or loans, or a combination of both, providing equitably (and to the extent practicable, on the basis of objective criteria) for variations between projects or classes of projects on the basis of the economic status of areas and sections, relative need as between areas and sections for additional facilities, and other relevant factors. Having regard for the economic status of the area or section and the ability of the applicant to pay part or all of the cost of the project, grants may be made for part or all of the cost; or loans may be made for part or all of the cost extending over a term not exceeding 35 years, with interest on unpaid balances at the rate of 2 percent per annum; or a combination grant and loan may be made for part or all of the cost, as the Surgeon General may determine.

"Sec. 6. Grants and loans may be made only to applicants in States which permit cooperatives and nonprofit associations to own and operate the facilities and to furnish the voluntary medical-care services provided in the purposes and conditions of this Act.

"Sec. 7. For each fiscal year the Surgeon General shall determine the total sum from the appropriation pursuant to Section 2 which shall be available for such grants and loans. He shall from time to time determine the amounts to be paid from such sums and shall certify the same, together with the times of payment, to the Secretary of the Treasury.

"Sec. 8. The Surgeon General shall carry out his functions as provided herein under the supervision and direction of the Federal Security Administrator. He shall, with the approval of the Federal Security Administrator, prescribe such regulations as he deems necessary to carry out the purposes of this Act. In carrying out his functions, the Surgeon General is authorized, pursuant to agreement between the Federal Security Administrator and the head of any Federal agency, to utilize the services and facilities of such agency and to pay therefor either in advance or by way of reimbursement, as may be provided in such agreement.

"Sec. 9. For the purposes of this Act—

"(a) the term 'medical care' means physicians' and dentists' services, hospitalization, and laboratory and X-ray services, and other services related thereto;

"(b) the term 'States' includes Alaska, Hawaii, Puerto Rico, the Virgin Islands, and the District of Columbia.

"Sec. 10. The effective date of this Act shall be the date of its enactment."

The objectives of S. 1805 will I am sure be clear to the committee. The basic aim of the bill is to encourage groups of people to take direct responsibility for the solution of their health-care problems. The bill would not offer assistance unless and until an organization of the people in need of more adequate care or living in an area of shortage of personnel and facilities had developed a sound plan for their own benefit and won the approval of the Surgeon General for it. But the point is that in many of the communities having greatest need and where there is the greatest readiness to act on their own behalf there simply is not the income necessary to finance facilities essential to a health program or to attract doctors to that area. The bill would remove this obstacle. It would apply the same general principle that has brought electricity to rural America to bringing adequate health care to rural and other communities which have need. The bill is thus a direct attack upon the problem of maldistribution of our professional personnel and facilities.

It is, we believe, furthermore an absolutely essential addition to legislation now on the statute books and even to other legislation now proposed. And for two reasons. In the first place, S. 1805 is not limited to hospital construction. Health centers and clinics could also be constructed under its terms. In many a rural community the people cannot and ought not to try to afford a complete hospital. But they can afford a clinic or a health center. Again, many a union health program requires clinic or health center facilities for its effective functioning. In very few cases would a union plan contemplate constructing a full-scale hospital. Second, the bill would make available, if need be, a combination of low-interest loans and grants. This is the feature that will make its benefits available to communities which cannot afford adequate facilities of any sort and also pay the current costs of medical care even on a prepayment basis. It is contemplated that loans would be employed wherever possible, but that where it is evident that the income of an entire group of people is so below the average of income for the Nation as to justify such action then part or all of the money would be made available in the form of a grant.

While I have spoken particularly of rural areas since the most acute shortages exist there, the terms of the bill by no means limit its application to rural communities. Its provisions apply equally to industrial areas where plans might be, or are already, organized and where need for assistance is evident.

Moreover under the terms of S. 1805 loans and grants could be made only to genuine and effective cooperative and nonprofit plans, the basic features of which are carefully set forth.

Needless to say we do not contend that the Humphrey bill is a cure-all or anything approaching it. But we do believe it is a sound measure from every point of view. It attacks the central problem of all—namely, the problem of whole communities whose total income simply is not enough to pay for adequate health care. And it attacks it by helping out in one clear-cut concrete manner rather than by any form of continuing subsidization. It proposes to help with the cost of facilities and by that means to bring the over-all costs of prepaid medical care within reach, or at least more nearly within reach of such communities. And it proposes to do this only where the people themselves have taken the initiative and organized a plan for the solution of their own problem. It is most earnestly to be hoped, that, whatever the fate of this or that particular measure this session of Congress will not adjourn until some significant forward step toward solution of the problem of the Nation's health has been taken. We hope and believe that our testimony has put before the committee a concrete and generally acceptable proposal to that end.

Before concluding this statement I should like to say that it has been impossible to discuss or even to refer to the many bills on the subject of health which have been introduced. For example, regardless of what one's opinion of its sweeping provisions may be a measure like S. 1970 can certainly not be overlooked. There has of course been little time for our organization to study this bill thoroughly and it has been clearly impossible for us to take a position with respect to it. I will say that that bill contains provisions in which our organization is naturally deeply interested and some of which, upon due consideration, our Board might well favor. We cannot refrain from adding that it is our very fervent wish that this great problem of the health of the whole Nation might be dealt with by legislation by bipartisan sponsorship and in an atmosphere of open-minded effort to simply find the best solution. In saying that I am confident that I am expressing the hope and wish of every member of this committee as well.

Here, then, are our two main points. First, the principle of insurance is a sound and necessary one for the times in which we live. Furthermore, insurance becomes more and more effective as the group of people covered is broadened. Hence it logically follows that universal insurance in which all the people are included is likely to be the best system of insurance, particularly where a general problem affecting all the people is involved. But the second point is that there is a vast difference between an insurance system on the one hand and medical service on the other. Whereas it is sensible to support a national program of insurance, it is equally important to insist that voluntary group action rather than any sort of compulsion be relied upon from the point where the insurance indemnity is paid. Although insurance works best where everyone or nearly everyone is covered in the program, on the other hand at the point where human relations become involved as they do certainly in the furnishing of medical services, there reliance should be upon voluntary group action and the initiative of the people. Every obstacle to the formation of such group health plans should be removed, they should be encouraged by every proper means. For upon them, rather than upon national insurance, we must depend for the bringing about of better distribution of professsional personnel and facilities, for improvement in the quality of service for advancing preventive care and for the real solution of the health problem at the only level where it can utilmately be solved, namely at the community level.

Mr. VOORHIS. Here are two main points. First, the principle of insurance is a sound and necessary one for the times in which we live. Furthermore, insurance becomes more and more effective as the group of people covered is broadened. Hence, it logically follows that universal insurance in which all the people are included is likely to be the best system of insurance, particularly where a general problem affecting all the people is involved; and I devote the first five or six pages of my testimony to proving—which I do not thing needs further proof—that this is a general problem in which the entire Nation has to be concerned, the problem of the people's health.

The second point is that there is a vast difference between an insurance system on the one hand and medical service on the other. Whereas it is sensible to support a national program of insurance, it is equally important to insist that voluntary group action rather than any sort of compulsion be relied upon from the point where the insurance indemnity is paid.

Although insurance works best where everyone or nearly everyone is covered in the program, on the other hand at the point where human relations become involved as they do certainly in the furnishing of medical services, their reliance should be upon voluntary group action and the initiative of the people.

Every obstacle to the formation of such group health plans should be removed, they should be encouraged by every proper means, for upon them, rather than upon national insurance, we must depend for the bringing about of a better distribution of professional personnel and facilities, improvement in the quality of service for advancing preventive care, and for the real solution of the health problem at the only level where it can ultimately be solved, namely at the community level.

In other words, Senator, as the testimony will show, the Cooperative Health Federation of America, of which I am the secretary, passed a resolution which is incorporated in the testimony on page 6, which read as follows:

> Whereas the Cooperative Health Federation of America has gone on record as favoring the principle of national health insurance provided that voluntary, direct service plans are promoted, encouraged, and protected; and
>
> Whereas the President has stated that such a program would be placed before the next Congress: Therefore, be it
>
> *Resolved*, That the officers of the Cooperative Health Federation of America consult forthwith the cooperative, farm, labor, and other consumer organiza-

> tions for the purpose of uniting views on essential elements of a national health-insurance program that relates to the promotion, encouragement, and protection of voluntary, direct service plans, and promote the adoption by the administration and the Congress of these views and the program.

I should explain that that resolution was passed by our last annual meeting last November. I might further explain that there are some organizations which are members of the CHFA which have not themselves taken a position on the question of health legislation of any sort, one of which is the health insurance plan of greater New York.

Now, then, Mr. Chairman, we are concerned about two things. We are concerned first and foremost about the general health of the people. We think we have learned enough in the last few years to recognize the general health of the people is something bearing upon national security, something bearing upon industrial production. We think we have found out that a lot of folks in the country who people once regarded as just being lazy, no account people, have just been sick.

We think that a great deal of that has been due to preventable disease and maladies of one kind and another. We think it most important therefore that preventive medicine be made a part of any program, and we think that it will be effective when people have prepaid the cost and when they are very conscious of the fact that they have prepaid the cost not only of curative but of preventive care.

We also feel that it is of great importance that something be done toward enabling people in areas of severe shortage of professional personnel and facilities to take action on their own behalf to correct that, and all the way through my testimony you will find that what we are basically after is first the removal of obstacles against the action of the people on their own behalf in this field, of which there are some, some serious ones, and second, that proper encouragement in the proper way be given to voluntary prepayment plans along with national insurance, if it is passed.

We do not in general like to see that assistance given on such basis that it would be a continuing sort of subsidy. We think that the critical point where it is needed is in the cost of facilities, and that there are many communities where, if adequate assistance can be given to a group to get the facilities that they need, that they will in many instances at least be able to carry the balance of their problem.

Now, then, Mr. Chairman, as I believe you are aware, our organization has suggested certain amendments to S. 1679 for the reasons that I have already briefly touched upon. One of those amendments would provide that there be inserted on page 133 of the bill a ninth standard for the acceptability of State plans for State administration, and our suggestion in that regard is this. The ninth proviso in the State plan should be inserted as follows:

> Provides for the right of any nonprofit association or consumer cooperative as named in section 716 to contract with physicians on a mutually satisfactory basis for the furnishing of services to their members.

Now, then, in section 716 it specifically says in the provision of personal health service:

> It shall be the policy to utilize individuals or organizations qualified under this part to render such services including any group, any organized group of individuals, any partnership association or consumer cooperative, any hospital, any organization operating a voluntary health service insurance program.

And so we would like to see some provision in the bill which would make it plain that where the people on their own behalf organize a plan and contract on a mutually satisfactory basis with physicians for comprehensive care for that group of people, that it shall not be excluded.

In the second place we have suggested another amendment which we feel is of importance and which I would like to put in its proper context, if I can. This second amendment has to do with assistance in the provision of facilities and it is printed on page 17 of my testimony. I will not take time to read it, Senator, because your time is running out.

I would like to compare it also with a bill which Senator Humphrey has introduced, Senate bill 1805 which aims at practically the same purpose. Some people will say that our request here is just like the Hill-Burton Act or that it is just like some of the other provisions in some of the pending legislation, but that is not true because the main thing that we are after, Senator, is to get effective assistance, the provision of facilities for comprehensive service plans.

That is, we feel that the place where a basic local solution becomes really effective is where the people organize to provide comprehensive service, preventive medicine and group practice for themselves, and we, of course, feel that that is our principal task in this field next to such contribution as we can make to the solution of the over-all problem, but we feel that to the extent that plans like that are available throughout the country, that they will offer an absolutely essential yardstick of service and of cost under any circumstances, whether you have got national health insurance or whether you have not.

We also feel that this is the way to answer objections to national health insurance which are sometimes made on the ground that it is going to take initiative away from the people, but where you have got a State law or discriminatory practices against doctors who associate themselves with a lay-sponsored plan, then there is a situation which says to the people, "You cannot act on your own behalf. You have got to wait for somebody else."

We want to remove that, and in the second place we recognize that especially in rural areas where many times there is the greatest dearth of facilities and personnel, that wherever the people may organize an effective and comprehensive care program they are in many communities quite unable to raise sufficient funds for facilities that they need.

We do not think that that is always a hospital center. We think that the proper pattern is a hospital in a certain well-decided-upon location with clinics and health centers around as a hub, and we think sometimes mistakes are made in communities in trying to build an expensive hospital when it just is not the right kind of facility, but we do want that kind of assistance for facilities.

Now, Senator, there is a lot more in here. There are my arguments for these two amendments together with argument for Senate bill 1805, but it is in case nothing else is done. There is also a discussion of meetings we recently had with the American Medical Association out of which there came acceptance by the AMA of a set of standards acceptable to the mfor lay-sponsored plans which, however, the AMA referred to State and local societies for original approval, and we would have much preferred to have that left in the AMA itself, because we realize that in some areas in the country that will mean a sympathetic understanding of what we are trying to do, and in other areas it just will not, but I would like to stop now and see whether there are any questions that anybody wants to ask of either myself or Mr. Dollar about this and about our general position in the matter.

Senator MURRAY. I was wondering what effect Senator Hill's bill, S. 1456, would have on your consumer cooperative health plans.

Mr. VOORHIS. Well, I have corresponded with Senator Hill about that some, Senator Murray, and I pointed out one thing which I think is important. I cannot find in Senator Hill's bill—and I might say that Senator Hill is a man that I very profoundly admire—anything that would give us any assurance that voluntary cooperative plans would be included, and I think that the way in which the bill is drafted State agencies which we know in many instances would exclude them, would have the say about the matter.

We would furthermore point out that Senator Hill's bill is limited to hospital care, and that we are concerned about comprehensive care not only in hospitalization but also of care in general.

I might say furthermore in answer to a question that I know might have been asked me had there been full attendance, that we think what is wrong with the means test is the people who just do not quite qualify, and furthermore the division of the people in a matter of this kind into groups and classifications, particularly classifications, where a premium is put upon people being able to show that they are unable to provide for themselves, and therefore we believe that the emphasis should be placed rather upon the problem as it affects groups and the people as a whole, and that we would much prefer to see Federal action taken to stimulate and to make possible effective action by whole groups of people.

That is why we lay as much emphasis upon facilities as we do, and why we even advocate that in certain very poor areas, that perhaps an outright grant for the entire cost of the facility might be made as a better means than the necessity of continuing Federal subsidy.

Senator MURRAY. There has been a lot of testimony in these hearings with reference to malingering, that under our plan they would be such a burden on the profession that it would hinder its operation. What do you think of that?

Mr. VOORHIS. Well, I have an opinion, but I want Mr. Dollar to answer it. He has got some figures that he put in testimony, I believe, before. Your remember them, do you not?

Mr. DOLLAR. I think it is not so much a matter of figures as it is a matter of experience. In our own prepayment plan here in the city of Washington we have in our membership the middle and upper-middle income group in the city, and definitely the upper educational level of the population, and I believe that experience would show that the tendency toward malingering is likely to be greater in that group.

They are more health conscious. They are more concerned with their individual health problems than in the lower-income groups, and yet we find, Senator, in our experience, that while there is some attempt at malingering, that we are able to control the problem.

The thing that so often is forgotten in these discussions of malingering under this kind of a program is the fact that under a program such as ours, and such as is anticipated under your bill, you still have a personal relationship between the physician and the patient.

You still have two personalities involved, and the physician will make certain that his time and efforts are not wasted on malingerers, and he is able, because he is in this situation, being the physician of the patient, to be in a superior role as the adviser and as the physician. He is in a position to bring effective pressure to bear on the patient not to take undue time.

Mr. VOORHIS. I would only like to say, Senator, I think where people feel they are a part of a plan where they are paying into that plan a certain amount of their income for medical care, that there will not be a tremendous amount of that sort of thing, and I do not think that any of our experience indicates that there is.

Senator MURRAY. What income groups are your voluntary plans now able to reach?

Mr. VOORHIS. It depends upon where it is located somewhat, Senator. I believe Mr. Dollar would say that his group would include what, Mel?

Mr. DOLLAR. I think that perhaps the income group above $3,600 a year makes up the bulk of our membership.

Senator MURRAY. Above $3,600 a year?

Mr. DOLLAR. Above $3,600. I just happen to have made a little analysis here of one of our groups that you might be interested in hearing about. In one of the Federal agencies here we found that of the 173 persons in a professional category, that we include in our membership 70 out of the 173. In that same branch agency there were 70 persons in the clerical classification, and of that group we have only 6.

Now we have made a real effort to reach the lower-income brackets in Government because we are concerned about their welfare, but we find it extremely difficult to sell to them a comprehensive service because it is just more than they can afford to pay.

Mr. VOORHIS. Now, Senator, I would like to supplement that by saying, however, that in connection with a good many of the rural plans, that the income level of people would be much lower than the one that Mr. Dollar mentioned, and furthermore, of course, his plan is a very comprehensive one that gives complete service, and that in connection with some of the plans affiliated with our organization, they have various packages where you can get complete service on the one hand or less complete on the other, and I believe that the income group would include a good many people in incomes lower than the figure Mr. Dollar mentioned in some of these other plans.

We do recognize, however, Senator, that if people have to pay the complete cost of care plus the cost of facilities, where there are not any, that there are all kinds of communities where the people just have not got the income to do it. That is why we feel that assistance in the provision of facilities is as important as it is.

If you have just one more moment I would like to make two points very clear. The first is that the people who have organized lay-sponsored health plans are the last people in the world to want to have anybody except duly qualified professional persons control the practice of medicine or decide what is going to happen in the treatment of a patient, and I would like to point out that in legislation that we have been interested in and in the Humphrey bill, that it is specifically provided that the doctor shall, in all cases, control the practice of medicine and decide how he treats his patients, and that that furthermore is in one of the standards which we agreed to with great alacrity with the AMA, and the other thing is that in connection with shortage areas, that the one way to bring doctors to a shortage area that is the best, is for them to feel that the people of that area have pooled together both their need and on a prepayment basis such resources as they have to pay for medical care for a whole group.

When they feel that they have got something solid to build on, you can bring doctors to shortage areas under those circumstances.

Senator MURRAY. Thank you for your testimony, both of you. The entire statement, of course, will be printed in the record.

Mr. VOORHIS. I will be much obliged, Senator.

Senator MURRAY. The next witness will be Dr. Charles M. Thompson.

Mr. Thompson, will you state your full name and the organization you represent?

STATEMENT OF CHARLES M. THOMPSON, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL DENTAL ASSOCIATION, ACCOMPANIED BY RUSSELL A. DIXON, PRESIDENT, NATIONAL DENTAL ASSOCIATION

Dr. THOMPSON. Mr. Chairman and gentlemen, my name is Charles M. Thompson, and I am a practicing dentist with offices and residence in the city of Chicago, Ill. Today I come before you as a representative of the National Dental Association which I serve as chairman of the committee on legislation.

With your permission I should like to have sit with me, Dr. Dixon, who is our president. He is also the dean of Howard University Dental School.

Senator MURRAY. I am called away for a few minutes. I will get back as soon as I can, but in order to be able to complete the testimony we will have to proceed with your statement and I will return as quickly as I can. I have got to go to a caucus in connection with a pending bill on the floor. I am very sorry I have to leave at this time, but you may be sure that your testimony will be given very full consideration by the whole committee.

Dr. THOMPSON. Thank you very much, Senator.

Now in its thirty-sixth year, the National Dental Association is the national organization of Negroes in dentistry. Dedicated to the highest aspects of the profession of dentistry, our association strives to improve public health, to promote knowledge of the art and science of dentistry, to advance the ideals and ethics of the profession, and to foster mutual improvement of the members of our organization and the profession generally.

Members of the National Dental Association labor in States of the Union where we are in constant contact with the people of our great Nation and in touch with the health needs of our population. It is with a sense of responsibility that we sought this opportunity to appear before your committee, Mr. Chairman, for the purpose of giving testimony on behalf of the legislation which is commonly known as the "National Health Insurance and Public Health Act." Specifically, the National Dental Association wishes to take this opportunity to endorse Senate bill 1679, the administration bill.

The National Dental Association is unreservedly in accord with the declaration of purpose of S. 1679 which describes the health of our people as "our Nation's strength, productivity, and wealth." We further subscribe to the principle that the—

> assurance of adequate medical care to all of our people is essential to the general welfare and to the Nation's security.

The NDA takes the position that adequate medical care and precautionary health measures should be a component part of our national life and that every citizen should have a right to such not as charity, but under, shall we say, a pay-for-what-we-get plan. The health insurance phase of S. 1679 in the Senate, and its counterpart bills in the House of Representatives, carry provisions for such a pay-as-you-go insurance. We sincerely believe that such a plan has merit.

Further, the National Dental Association condones the terms of these bills which take into consideration our national needs for more medical, dental and allied personnel, and the dire inadequacies in the area of health and medical facilities. We approve, therefore, without reservation phases of these bills which treat segments of health education with the intention of removing causes that attribute to the shortage of physicians, dentists, nurses, medical and health technicians, and at the same time foster the establishment of research centers and medical facilities which are needed in all sections of the Nation.

It may be assumed that we testify on behalf of Negroes exclusively. Such an assumption, Mr. Chairman, we sincerely hope this committee, will not take. As I have pointed out earlier in this statement, the National Dental Association is interested in a national insurance plan and a national health program which takes into consideration the health needs of all the people, irrespective of race, religion, or any condition of life.

Further, Mr. Chairman, it might be assumed that our testimony is in support of fields of governmental activity which might deal specifically with health as it relates to dental health. This assumption, too, would be a false one. As dentists, we know that oral diseases cannot always be treated as matters that are distinct from the general health of a person. We know that general health is an all-inclusive problem, if I may term it such.

Then it might be assumed that as members of the National Dental Association—an organization of Negro dentists—we are interested in these bills because we feel that persons whom we represent will gain financially from the flow of additional funds into our States and localities for health welfare. In the case of Negro dentists, this would not necessarily be true. There are but a few more than 1,600 Negro dentists in the whole of the United States. The vast majority of these men have substantial practices and reasonable incomes. You notice I say "substantial practices and reasonable incomes."

Our first interest is the health and welfare of the Nation. This objective we view in a broad national perspective. Second, we are interested in the health and welfare of the minority with which we are identified. In connection with this group, we see vast lots of people who are unable to afford adequate health care. In certain sections of the country, we see social customs and community patterns which deny Negroes access to medical facilities. Then we see great shortages of medical, dental, and allied personnel among Negroes in particular.

In addition to urging the retention of the provisions of S. 1679 which would tend toward a solution of the above ills, we stress the need of such safeguards as would assure receipt by minority groups of all of the benefits of the National Health Insurance and Health Act. We have no irreconcilable differences with regard to the location of administrative responsibility for such laws, be it local, State, or Federal. But we do feel that every possible precaution should be made to assure Negroes a satisfaction of their needs in all of the areas that the prospective law covers.

The National Dental Association feels that the following items, as covered in these health proposals are of primary concern to the Negro population of our Nation: (1) An increase of medical and dental manpower; (2) an increase of hospital facilities; (3) rehabilitation of disabled persons; (4) creation of more medical and dental research centers; (5) provisions for local citizens health councils, and (6) establishment of an adequate over-all health-insurance plan.

Mr. Chairman, we of the National Dental Association honestly believe that S. 1679, and its counterparts in the House of Representatives, that is, bills H. R. 4312 and H. R. 4313, would offer adequate coverage for the national health needs of our people, that these bills are the most comprehensive that have been before the Congress of the United States, and we believe further that they are administratively sound, and that they would afford a high quality health service for our people.

The National Dental Association is on record in support of previously proposed legislation designed to improve the health of the Nation. Such legislation covered the basic principles which underline S. 1679. It is, therefore, the common and unanimous belief of our legislative committee that the membership of the association will continue to support such type of legislation.

We, therefore, endorse these bills and respectfully urge that this committee favorably report S. 1679 to the Senate Committee on Labor and Public Welfare.

Mr. Rodgers. Thank you very much, Dr. Thompson.

Dr. Dixon, do you have anything to add to Dr. Thompson's remarks?

Mr. Dixon. No. I agree with the general context as presented.

Mr. Rodgers. Dr. Thompson, perhaps the committee staff members will want to ask you some questions.

Mr. Reidy?

Mr. Reidy. Senator Murray asked that if he did not get back on time, I put some question to you. On page 2 of your statement you listed a series of six requisites for adequate health, beginning with an increase of medical and dental power and ending with the establishment of an adequate over-all health-insurance plan.

Now it has often been suggested at these hearings that, because we need items 1 to 5 in your statement, we should postpone health insurance until all these others are accomplished facts, until we have more doctors and better distribution of facilities. On the other hand the position has been taken that without compulsory health insurance guaranteeing that the funds will be available, we cannot get the people into the field and we cannot get them properly distributed. Would you have an opinion on that one way or the other?

Dr. THOMPSON. I would. I believe that in ordinary times, most of the time of the professional man is not consumed, and there is available time that could be used, and I think the experiment should be attempted, not that there are some things we would like to change in it, but we think it is a grand experiment that ought to be tried and changes could be made as the thing progresses.

Mr. REIDY. The second question was this: It has often been stated that because of the extreme shortage of dentists in the country—there is a shortage of physicians, too—that you simply could not come near to providing the services called for under the Health Insurance Act, and that therefore sponsors of the bill would be well advised to just leave dentistry out of the bill entirely—to put through a health-insurance bill and leave dentistry out until we get a considerable increase in the number of dentists available.

It has been pointed out on the other side upon occasion that providing medical care necessarily involves providing care for the mouth, that if you left dentists out, then in cases involving victims of automobile accidents affecting dental structures, it would mean that dentistry as a profession would be discriminated against and that therefore they should be included in the bill. What do you feel about the shortage of dentists?

Dr. THOMPSON. I think there is definitely a shortage of dentists throughout the whole of the United States. I do not believe that there would be enough dentists to carry out all the provisions of the bill. I do not subscribe to the theory that because you cannot get complete dental coverage, that you should give none.

I think we should give as much as we can afford to give. I think that might well be settled by the dentists themselves on what they might be able to give.

Mr. REIDY. Would the passage of an act which guarantees payment for services when they become available encourage more people to go into the profession known that money would be available.

Dr. THOMPSON. I am sure it would be an incentive.

Mr. REIDY. Then as regards title I which, as you know, provides funds for Federal aid to medical and dental education, the Senator wondered whether you had any comments, especially on one specific point as to whether you now have amongst Negro youth applicants for the profession who find that they cannot get an education in the profession because of the shortage of facilities or lack of funds necessary to go through the long years of training needed.

Dr. THOMPSON. I am rather glad you brought that question up, Senator, because it refreshes my mind on something that I want to mention.

Mr. REIDY. You are promoting me. I am just a consultant to the committee.

Dr. THOMPSON. Well, Senator Murray stated a moment ago that members of the medical profession were advising this committee on certain services, and I was wondering if on that committee there had been appointed some Negro, and if it had not been done——

Mr. REIDY. Actually, there was no formal committee set up; just individuals to help go over the details of the bill, at which time Howard University was consulted. We have been in touch with Howard University and Meharry.

Dr. THOMPSON. We have only two schools which give dental education at the present time, and Howard University can only take about 50 young men a year, and Meharry can only take about 35 young men, and the other schools all over the country have perhaps only 30. I myself happen to be a graduate of Northwestern University; there is a great shortage of facilities for Negro students.

This much is true. There is an effort on the part of most schools, I think, to become much more liberal. In Chicago we have a commission on health of which I happen to be a member, and certain of our local schools, also; we are doing a very fine job, I think, on opening up these schools to a great extent. In the matter of finances, I think that goes for almost all young fellows, whatever their race, that they find difficulty in obtaining money to go to school, so I think that would be a help to many young men.

Mr. REIDY. I have just one last question along that same line. There has been testimony to the effect that inasmuch as every medical and dental school in the country now has more applicants for admission than it can possibly accept, that there is no point to the Federal Government starting to provide scholarship funds for students to attend those schools. Would you have any comment on that?

Dr. THOMPSON. Of course, after each war, certainly after two wars there is a great rush for medical and dental education, because men have been out of school over a period of years. Also because the Government assists them in going to school, more men are able to go to professional schools.

I think then by the same reasoning if the Government over a long pull guarantees certain professional education to people over a period of years, the schools will realize that this thing will not be a temporary thing, which it has been in the past.

After the First World War there was a large enrollment over most of the schools, and during the depression there was a lag. The students did not have the funds to go to school. They were begging for students. Now, after this war, you have the same thing all over again, an ample supply of students based on two things: The fact that young men have been detained because of the war, and the fact that the Government is assisting them in going to schools.

I feel, therefore, if the Government does make this assistance available, the schools will enlarge their facilities and will be justified in so doing.

Mr. REIDY. If I understand you correctly, then, I think you have introduced a new idea here, that the scholarships are a necessary aid to the granting of funds for construction, because unless the schools are assured a continuing supply of students, there is no sense in expanding facilities.

Dr. THOMPSON. That is right.

Mr. RODGERS. Mr. Sneed, do you have any questions?

Mr. SNEED. No; I have not.

Mr. RODGERS. Thank you very much, gentlemen. That completes today's schedule. These hearings will be resumed at 10 o'clock tomorrow morning in this room.

(Whereupon, at 11:35 a. m., the hearing was adjourned, to reconvene at 10 a. m., Tuesday, June 21, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

TUESDAY, JUNE 21, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senator Murray.

Senator Murray. The hearing will come to order, please.

The first witness this morning is Emmet Slusher, president of the Missouri Farm Bureau Federation, appearing on behalf of the American Farm Bureau Federation.

Mr. Slusher?

STATEMENT OF H. E. SLUSHER, PRESIDENT, MISSOURI FARM BUREAU FEDERATION; CHAIRMAN OF THE HEALTH COMMITTEE, AMERICAN FARM BUREAU FEDERATION

Mr. Slusher. Mr. Chairman, and members of the committee, my name is Emmet Slusher. I own and operate, in partnership with my son, a farm in Lafayette County, Mo. I am president of the Missouri Farm Bureau Federation. I am a member of the American Farm Bureau Federation board of directors and chairman of the federation's health committee. I am not a doctor.

On behalf of the 1,325,000 farm families that compose the membership of the American Farm Bureau Federation, I want to express our appreciation for this opportunity to present our views with regard to pending proposals establishing a national health program. Ours is a national farm organization, with its membership on a farm family basis. Members pay dues voluntarily to finance the activities of the organization.

With the understanding that detailed consideration will not be given to the five bills on which hearings are being held—S. 1106, introduced by Senator Lodge, to provide assistance to the States in furnishing certain medical aid to the needy; S. 1456, introduced by Senator Hill; S. 1581, introduced by Senator Taft, to enact a National Health Act of 1949; S. 1679, introduced by Senator Thomas of Utah, to provide a program of compulsory national health insurance; and S. 1970, introduced by Senator Flanders of Vermont, to facilitate the broader distribution of health services—my statement to the Committee will be general in character.

This statement is based upon the recent resolutions adopted by the 45 State Farm Bureaus and the 1948 resolution of the American Farm Bureau Federation.

There is no disagreement as to the desirability of the highest medical service and best facilities obtainable. The difference of opinion comes in how best to attain these objectives. The individual farm family is fully aware of the privileges and responsibilities of American citizenship. They realize there is no escape from individual responsibility. They realize the necessity for rural and urban people alike to develop sound programs. No other group of our society holds more firmly than farmers to the idea that the Government should do for us only those things which we cannot do for ourselves.

Farmers believe that they themselves first should make every effort to solve the problem. Failing in this, then the community should help. If the problem is too big for the community, then the State should step in. The Federal Government should be called upon only as a last resort. Regardless of how much the Government puts into a health program, we will not solve our health problem if the individual family is not interested, if the family is not willing to work for better health.

Farmers have produced abundantly, knowing that a program of improved diets for the American people can contribute substantially to improving the health of our citizens and to the welfare of our country. They have come to realize the importance of feeding the soil proper mineral elements in the form of fertilizer in order to grow health-building foods. We have continuously supported an expanded school-lunch program, realizing the value of food in the growth and development of children and realizing that illness in later life may be a direct result of improper nutrition during childhood. The farmers of the Nation, through their efforts to produce better foods and feed, have always demonstrated their interest in the health of the people of the Nation.

Farm people recognize that the quality of American medical service is very high. They are proud of the quality and availability of that service in most areas. Nevertheless, they are well aware that in some sections, service is not available, or at best, limited. Rural areas are generally less well supplied with physicians than urban areas. Knowing that this has partly resulted from lack of adequate professional facilities, the American Farm Bureau Federation supported enactment of the Hospital Survey and Construction Act of 1946. State Farm Bureaus throughout the country have been leaders in assisting State and local governments to take advantage of the provisions of the act in order that rural areas might be better served. While progress under this act may be slower than some would desire, we nevertheless feel sure that it is a sound program which preserves the rights of the States and the people of the States. It is they who decide under their own free initiative the extent of their participation in the program.

The Farm Bureaus have recognized promise in the long-range health education program carried out by the Agricultural Extension Service. We have urged the Land-Grant Colleges to expand this program to the extent that they have an extension health education specialist on their staff. This is important in teaching rural people the meaning of high standards in hospital and medical care. It is important to teach the advantages of budgeting the costs of medical need as they do other household expenses. They must know the significance of health hazards around the farm home as they pertain to disease, including the relationship between animal diseases and human health. They must know what services offered by public and voluntary agencies are available to them, and they must discover their own health needs and formulate their own programs.

As means of encouraging such a program, county and State health councils have been set up by the local people. Lay people, professional people, and organizations cooperating together can do much to solve their own health problems under such a program.

Farm people realize that they cannot have, nor do they expect to have, doctors and medical facilities as close to them as people in urban centers. They recognize that this is one of the disadvantages of living in the country—a disadvantage which has to be offset by the privilege of living out-of-doors, free from the health dangers of living in a congested area.

Recently I traveled through the sections of western Nebraska and South Dakota, which were blizzard-swept in the winter of 1949. From the second of January into March, the people of that area were snowbound. Many babies were born. Yet, due to the ingenuity and resourcefulness of the people themselves and of the community, and with a minimum of national help, these babies were born in a hospital, none the worse for a helicopter ride.

The American Farm Bureau Federation and the State Farm Bureaus have cooperated in cancer, tuberculosis, venereal disease, polio, crippled children, heart, and rheumatic fever programs. We sincerely hope that our efforts in furthering these programs have been of value in making all farmers conscious of the threat of these insidious diseases as well as the need of recognizing early symptoms—which, if recognized in early stages, may by treatment, prevent death.

The American Farm Bureau Federation has supported grants to States for maternal and child health programs, and programs to assist States in the expansion of needed public health services and facilities. We have insisted, however, that to the extent Federal grants are needed by way of assistance, such grants should be made to States on the basis of need, with State governments responsible for the allocation and administration of the funds made available. It is our firm conviction that the State and local authorities are best informed on local needs, and in them should be lodged the administration of such health programs. Thus, the American Farm Bureau Federation has favored the objectives of legislation providing that the Federal Government should reasonably extend its public health programs with respect to public health services and medical care for those unable to provide such care for themselves. We insist at all times that the rights of the States to develop their own program should be safeguarded.

We also urge that facilities of medical schools be expanded, and that every effort be made to train more physicians, surgeons, dentists, nurses, technicians, and general practitioners and public health doctors. We feel there can be no real solution to the health problem until sufficient men and women are trained to meet the need.

With the expansion of professional facilities now being made possible by the Hospital Construction Act, and looking forward to the education and training of additional men and women in the medical and dental fields, the important question remains to be resolved as to what type of program may best assure that rural people will be able to continue to secure needed medical and dental services. It is our opinion that this can best be accomplished through voluntary health insurance programs. This has been our view over the years. Nothing has happened recently to change the basis for this position.

The "pay as you go" system is not necessarily suited to the needs or convenience of many people. The solution seems to lie in group financing through voluntary membership in health insurance associations.

The degree of medical care should be improved and extended. It should be done in a democratic way—not by a program of compulsion which violates our most cherished heritage—that of individual initiative and freedom.

It is our feeling that the existing voluntary health insurance plans have demonstrated the merit and feasibility of such plans. Fifty-five million Americans are now covered under voluntary health-insurance systems, and 37,000,000 are insured against surgical and medical bills. This remarkable showing has been accomplished largely during the last 12 years. We believe it is a correct assumption that in time the established and successfully operating plans would go out of existence with the enactment of Federal legislation setting up a tax system for the support of a national health insurance program. On the other hand, under a carefully worked-out program of expanded activity, there is every reason to believe that coverage can be extended to include all but the indigent. Under any program, the latter group will always have to be considered separately.

I think we should bear in mind that medical, hospital, and related individual health care in this country are now the best in the world. We have reached this unique position through efforts made under democratic processes. The analyses of our present program have yet to prove that the program has failed. We oppose a national compulsory health program.

We oppose a national compulsory health program for four very definite reasons:

First, there are no facts to prove that there is a need for such a program.

Second, no country operating under a compulsory health program has as high a health standard as has this country.

Third, such a program would be prohibitive in cost.

Fourth, the people have not asked for such a program.

This does not necessarily mean that we should sit idly by and maintain the status quo. An expanded educational health program should be carried out. A great deal can and should be done to extend coverage and benefits under voluntary health plans. A great deal can and should be done to further medical research; to further education in medical, dental, nursing, and related professions; to extend greater aid for maternal and child health, and crippled children's services and aid to the blind. We also favor continuation of aid for construction of facilities, including school facilities, to assure adequate professional services for all. These things are needed and can be done in our traditional way without a compulsory health insurance program.

In conclusion, let me emphasize again the importance of analyzing rather carefully the entire health problem and the need for a new program before we say that the old has not made sufficient headway. We should satisfy ourselves beyond a reasonable shadow of a doubt that a compulsory program will better the health standards of this Nation. We should satisfy ourselves that in our attempts to raise our physical health standards, we do not lower our moral health standards. Such a thing might well happen, and then the entire world would indeed be sick.

Thank you, gentlemen.

Senator MURRAY. Your organization represents, you say, 1,325,000 people?

Mr. SLUSHER. That is right.

Senator MURRAY. Have you polled the membership of your organization on this matter?

Mr. SLUSHER. Not individually. We have taken the resolutions adopted at the State annual meetings in 45 States, and the resolution adopted by our own annual meeting of the American Farm Bureau Federation.

Senator MURRAY. Are you familiar with polls that have been taken in various parts of the country on this same matter?

Mr. SLUSHER. No, sir; I am not.

Senator MURRAY. You only know about the members of your own organization. You are not familiar with the attitude of the people of the United States, generally, on this subject?

Mr. SLUSHER. No, sir; only those of our own organization and as we come in daily contact with farmers and other people all over the country.

Senator MURRAY. You do feel that your organization, that is, the farmers of the country, have made a considerable contribution to the health and welfare of the American people?

Mr. SLUSHER. We certainly feel that we have.

Senator MURRAY. You do not agree then, with the American Medical Association that they are totally responsible for all of the good conditions that prevail in the United States with reference to the health of the American people?

Mr. SLUSHER. I think we can go back to the statement that I made: If the individual families themselves don't want good health, the doctors, nor nobody else can give it to them.

Senator MURRAY. Do you think there is much of an attitude among the American people, that they don't want good health?

Mr. SLUSHER. Not directly. I think they need more education, probably.

Senator MURRAY. I see.

Mr. SLUSHER. As to where they should spend their money, in other words.

Senator MURRAY. You think the people of the United States, generally, are so uneducated, and incompetent that they don't know how to take care of themselves, and they should have better education in order to be able to protect their health?

Mr. SLUSHER. I think most any of us could do a better job of taking care of our health, if we were so minded, and put the emphasis on health, rather than on the other things we do.

Senator MURRAY. And you don't think that money has very much to do with the health of the American people?

Mr. SLUSHER. I know a lot of people with a lot of money that are not very healthy.

Senator MURRAY. That is true, but you know a lot of people, too, that are in bad health because of the fact that they didn't have the money to provide good health for themselves.

Mr. SLUSHER. You have cited a case, of course; and you could say the same thing about a lot of people in bad health, because they don't have proper food and, if we are going on the theory that the Government should provide individual good health, maybe the Government could provide good food, too.

Senator MURRAY. Don't you think the Government should provide conditions in the country where the people would be able to secure good food and secure good health services?

Mr. SLUSHER. Only as the individuals themselves cannot do it, if they are willing.

Senator MURRAY. You believe in the doctrine of rugged individualism as the chief thing for the bill of fare of the American people.

Mr. SLUSHER. I would't put it that way; no, sir.

Senator MURRAY. You wouldn't?

Mr. SLUSHER. No, sir.

Senator MURRAY. You say that the cost of a program such as is proposed in the Thomas bill would be prohibitive.

Mr. SLUSHER. I sincerely think that is true.

Senator MURRAY. That is one of the main reasons for your objection to it, because of its prohibitive cost?

Mr. SLUSHER. We have very little to indicate that the Government can do anything cheaper for us than we can do ourselves.

Senator MURRAY. Even in the matter of health, or even in the matter of subjects which require such resort to science and high training, you think there is very little than can be done for the people that they can't do themselves?

Mr. SLUSHER. The Government can help with that phase of it; but, so far as collecting the doctors' bills and apportioning it back out, I don't think they can anywhere near do an equally good job as we can do ourselves.

Senator MURRAY. So you think the proposed bill, the Thomas bill, because of its cost would be prohibitive?

Mr. SLUSHER. I do.

Senator MURRAY. What would it cost the American taxpayers of the country?

Mr. SLUSHER. I am not an economist.

Senator MURRAY. You don't have to be an economist to know that. You say it is prohibitive. You must know something about why it is prohibitive.

Mr. SLUSHER. I think, if you take anywhere up to 10 or 15 percent of our income, I would say it is going to be pretty expensive.

Senator MURRAY. You think it would be say 10 or 15 percent of the national income?

Mr. SLUSHER. Of the income of the individual.

Senator MURRAY. The income of the individual?

Mr. SLUSHER. That they would have to contribute.

Senator MURRAY. Do you mean to say it would require that much in taxes to supply the care that we propose here?

Mr. SLUSHER. Yes, sir, I do.

Senator MURRAY. Don't you know that we are already spending, under the system that is now in operation something like—is it 5 billion? Between 5 and 5½ billion a year in medical care.

Mr. SLUSHER. You mean, on the part of the Government?

Senator MURRAY. No, on the part of the people, the American people.

The American people are spending 5½ billion dollars a year for medical care. You know that, don't you?

Mr. SLUSHER. I don't have that figure.

Senator MURRAY. That is a figure that is conceded by everyone involved in this controversy. The American Medical Association acknowledges that. How much in addition to that would be required to carry out this program, do you know that?

Mr. SLUSHER. The figures that I have seen, and discussions of the cost, and figuring the cost—England is probably the closest to us, and it runs considerably more than we are paying today for the average individual.

Senator MURRAY. That is not exactly the question. I am not asking what the situation is in England. I am asking you if you know what additional burden it would be on the taxpayers of the United States, under this bill, to furnish good modern medical care to all of the people of the United States.

Mr. SLUSHER. I don't know any exact figures, Senator; but, I do know that from our experience with Government administered programs of this kind, it would be far in excess of a voluntary program, if everybody would go into a program voluntarily.

Senator MURRAY. Of course, you will admit, yourself, that those are vague conclusions. You have no actual facts, you are just assuming that it will be vastly more expensive than the present system.

Mr. SLUSHER. Senator, wouldn't you concede that there is no dollar that ever goes to Washington and comes back out to the State as large as it was when it went to Washington.

Senator MURRAY. Where are the dollars going to come, to the city of Washington, in connection with this proposal?

Mr. SLUSHER. They will come out of the taxpayer's pockets, or the laboring man's income.

Senator MURRAY. You have the notion that under this program the people of the United States would be taxed and the money would come to Washington and wouldn't get back out to the people?

Mr. SLUSHER. Theoretically, because you will have your administration costs here in Washington, it cannot be helped, and those costs——

Senator MURRAY. What would be the cost of the administration here in Washington in connection with this program?

Mr. SLUSHER. You would have the cost of your filing, your records, your administrators—all of those costs.

Senator MURRAY. Don't you know that we already have, set up in Washington, the administration that will carry out that program, and is already carrying out a social-security program, and the additional work it would have to do would be somewhat small in comparison to the whole task?

Mr. SLUSHER. I think that is an assumption.

Senator MURRAY. You think that is an assumption?

Mr. SLUSHER. Yes, sir. I don't know of any department down here that is willing to undertake more work without more help.

Senator MURRAY. You agree with the American medical propagandists that this program of ours is a political program that is being proposed by a few politicians here in Washington, and is not something that the people of the United States want at all?

Mr. SLUSHER. Senator, I don't think it would be fair to you, knowing your position in this matter, to make a statement like that.

Senator MURRAY. You don't believe that this is a political program advanced by a couple of politicians?

Mr. SLUSHER. I wouldn't say that. I think probably there is more interest in a program of this kind at the higher levels than there is among the people themselves, at least in the rural areas. I don't know anything about the city people, whether they are clamoring for a compulsory health program or not, but I know the country people are not.

Senator MURRAY. The country people are not clamoring for that?

Mr. SLUSHER. Not clamoring for a compulsory health program.

Senator MURRAY. We have had witnesses for the last 8 years coming from the rural sections of the country telling us how badly needed a program of this character is. In fact, it was from the farmers of the United States that I became first interested in this problem. They came here from all parts of the country, from the South and the West, and told us about the conditions that prevailed there, and that there was some need for a program of this kind. I cannot understand—what States is your organization in? Is your organization in the State of Missouri? It is, is it not?

Mr. SLUSHER. It is in 45 States of the United States.

Senator MURRAY. And is it that way in all the 45 States? Do you represent the whole 45 States covered by your organization?

Mr. SLUSHER. Today I am representing the Farm Bureau membership of those 45 States.

Senator MURRAY. Anyway, you take the position that this program would be prohibitive when, as a matter of fact, it would only cost something around six or seven or eight billion dollars a year.

Mr. SLUSHER. To start.

Senator MURRAY. What?

Mr. SLUSHER. To start.

Senator MURRAY. Well, to start. Don't you think that if a program giving complete medical care to the American people, expanding medical education, and expanding hospitals and clinical establishments around the country, would have a tendency to greatly improve the health of the American people?

Mr. SLUSHER. Spending that much money, it certainly should.

Senator MURRAY. Don't you think then, as a program of that character went forward, that the American people, having the opportunity to go to doctors when they think they should, and not be compelled to hold back because of the financial problem involved—that they would be better taken care of, and they would have better health.

Mr. SLUSHER. Yes, sir; but how long do you think it would take to get enough doctors in this country to take care of people that way, who were going to doctors just because their doctors' bills were already paid?

Senator MURRAY. If we have a program today—now, this bill provides for a program of medical education and for training of hospital personnel, superintendents and nurses and so forth, which everyone in the United States acknowledges is necessary.

Mr. SLUSHER. I had rather see the emphasis placed on better nutrition, better food for our people, and voluntary programs whereby they could put forth the necessary effort and initiative to take care of their own conditions, rather than to see the United States Government do it for them.

Senator MURRAY. And the general application of the doctrine of rugged individualism.

Mr. SLUSHER. I don't call it that. I think the United States Government again should do those things for us only which we are not able to do in our own local communities.

Senator MURRAY. At any rate, you think this program of ours would be prohibitive. That is one of your objections to it, because of prohibitive costs; and yet, you know that in the late war we spent many billions of dollars killing people and created a debt in this country of several hundred billion dollars.

Mr. SLUSHER. Well, we all hope that is money well spent.

Senator MURRAY. You hope it is money well spent. You hope, as a result of it, we are going to get peace in the world, but it looks kind of gloomy right at the present moment. We are all hoping, of course, that a program will eventually be worked out that will bring peace to the world. But the point I am making is, we spent hundreds of billions of dollars killing people, and this program only involves very few billions of dollars to improve the health of the people and I don't see how you can refer to it as a matter involving prohibitive costs.

Now, you say that no country operating under a health-insurance program has as high health standards as this country.

Mr. SLUSHER. I think that is a sound statement.

Senator MURRAY. Do you know that several countries are way ahead of us in infant mortality? New Zealand, Norway, and Sweden, with health insurance, are ahead of us in that direction.

Mr. SLUSHER. Have they made as rapid development along that line in the last 10 years as we have?

Senator MURRAY. Well, I don't want to prolong this examination. I merely wish to point out, however, to you, that the information that we have received in this committee, for the last 8 or 10 years, from groups that have contained farmers from all parts of the country, has been to the effect that there was great need for a program of this kind in rural areas.

Mr. SLUSHER. Senator, our organization is the largest farm organization in the United States, and in the world, for that matter; and, I don't think you would find any organization in which the democratic processes more nearly function in the development of resolutions and policies than in our Farm Bureau organization and that certainly isn't the stand that our Farm Bureau people have taken.

Senator MURRAY. Does your organization favor the rural electrification program?

Mr. SLUSHER. We certainly do.

Senator MURRAY. That is somewhat socialistic, is it not?

Mr. SLUSHER. I wouldn't say so.

Senator MURRAY. You wouldn't say so? It collects money from the taxpayers of the country; it provides for Government contributions, or Government construction of transmission lines and projects to create electricity; it helps to put electricity out to the farmers of the country; it has an administration office here in Washington, and money is collected and goes into a bureau in Washington, and——

Mr. SLUSHER. That is a service that the farmers were unable to provide for themselves, under the old program.

Senator MURRAY. The farmers are not able to provide for the medical care for themselves, either.

Mr. SLUSHER. We think they are.

Senator MURRAY. They cannot provide their own doctors and have them right there on the farms, they have got to——

Mr. SLUSHER. I would hate to see the day come when the Government would try to put a doctor on every farm. I don't think we need that.

Senator MURRAY. The Government isn't proposing anything of that character, of course. The Government is merely proposing to put hospitals in parts of the country where they have not had them before, and provide doctors where they haven't got them now.

I have been into some rural areas of Montana where they only had one doctor in the whole area, and he told me himself that he was preparing to leave there, because he was dissatisfied with the conditions that prevailed in that section, and he wanted to get away to a city where he could educate his children better, and have better access to schools and colleges.

Mr. SLUSHER. That was one point that I did not bring out.

I think the economic conditions in the rural areas has a lot to do with whether the doctor is going to be there or not, and I don't think that even the Government, with an insurance program, would necessarily mean we would have a doctor there unless you paid him a salary beyond what he could get in the cities, because he is concerned with his family, and his family's living conditions, environment, and opportunities and those things we have to recognize, and the doctor that does settle there has a different motive than just making money, or something of that kind. He is going to want to live in the country before he goes out there.

Senator MURRAY. Our program contemplates the building of hospitals in areas where they don't exist, and the establishment of clinics to make it possible for doctors to practice better medicine than they can under existing conditions, and, in that way, it induces doctors to practice in an area where they have those facilities.

Mr. SLUSHER. We are 100 percent for the program of getting more hospitals, county health units, and facilities of that kind out there; and I think the Federal Government will have to help us to some extent to get those facilities.

Senator MURRAY. Thank you for your testimony.

Mr. SLUSHER. Thank you, sir.

Senator MURRAY. The next witness will be Dr. Theodore M. Sanders, on behalf of the National Consumers League.

STATEMENT OF DR. THEODORE M. SANDERS, ON BEHALF OF NATIONAL CONSUMERS LEAGUE

Dr. SANDERS. My name is Theodore M. Sanders; I am a physician and have been practicing internal medicine in New York City ever since my discharge from the Army Medical Corps after the First World War. I am a visiting physician at a voluntary and a municipal hospital in New York; I am also a member of the New York County Medical Society and the American Medical Association.

I am appearing before this committee to support S. 1679 as a representative of the National and the New York State Consumers League. I am a member of the board of directors of both organizations which are concerned with the improvement of working conditions through such measures as raising minimum wages, safeguarding the migrant worker and broadening the scope of our social-security program.

A national program of health insurance seems necessary to me as a physician, familiar with the shortcomings of our present methods of distributing medical care. The necessity is even more apparent when the situation is considered from the point of view of the consumer of medical care, the patient. Indeed, I have been accused of viewing the problem from the standpoint of a social worker rather than a doctor; since I assume this means that I am aware of the social aspects of medicine, as well as the scientific, I do not object in the least to this charge.

As I see it the science of medicine has reached a point where it is a very expensive commodity, involving many complex but necessary and costly procedures. Many Americans, often those who most need it, simply cannot afford to pay for the cost of a serious illness or even for the essential diagnostic and preventive measures which are necessary to maintain health. Our problem, then, is to make these essentials available to everyone and in the process to make maximum use of our existing medical and hospital facilities; to see that the facilities and the physicians are distributed throughout the country where they are most needed and that, above all, there is no economic barrier preventing anyone from getting good medical care.

There is a rather prevalent concept that this group, those who cannot afford good medical care under our present system, are the so-called medically indigent. I will not quarrel with this designation if the group is accurately delineated. In point of fact, nearly everyone, except the very rich, is potentially a medical indigent, depending on the gravity of the illness, its duration and cost. Virtually, any doctor and any hospital superintendent can tell you the story of individuals, self-reliant in every respect, except when serious illness strikes. I have seen many such people start off in a private room, move down after 3 weeks to semiprivate, thence to the ward, and finally to be transferred to the city's charity wards if the illness lasts long enough.

Conversely, I think any honest doctor will agree that most healthy people spend less than they should on maintaining their health—just as they are forced to spend too much when illness strikes.

Now, there are those who believe that this problem can be solved through the medium of voluntary health-insurance plans. I am afraid this is simply wishful thinking. Just because they are voluntary plans, the individual who most needs this protection does not join them; there are too many other demands competing for his dollar.

Only last week I saw a member of the New York City detective force, earning $2,800 per annum, who was heavily in debt after an operation and long hospitalization for a perforated peptic ulcer. He did not even have hospital insurance, simply because of chance—the sales campaign had passed him by. This man is not the exception—indeed those who join are the exception when the Nation's working force as a whole is considered.

This seems to me the basic weakness of the voluntary plans; they simply do not include all those who need protection and they never will.

There is another major defect in the voluntary plans, particularly those sponsored by the State medical societies. Almost without exception they are based on the premise that the low-income group must be protected only from the cost of catastrophic or hospitalized illnesses. It seems scarcely necessary to argue that preventive inoculations, home care and office care are equally necessary; that many diseases can be prevented from becoming catastrophic if adequate care is given early in their course.

This emphasis on the hospitalized illness as the focal point of a health plan is unsound. It runs counter to the efforts of progressive municipalities like New York City which has recently developed a plan to relieve the pressure on the hospitals by removing patients early to their homes and providing them with the equivalent of ward medical and nursing care and even housekeeping service.

It does not seem to me that we can hope for any thoroughgoing solution of the health problem through voluntary means any more than we can hope for effective public education on a voluntary basis. Except for the Blue Cross hospitalization plan—which is by no means as all-embracing as some of its proponents would like to suggest, the voluntary plans to date have simply not done the job. People just don't join, in any impressive numbers. In my own practice, for example, I have been remunerated just once by a member of a voluntary health plan—and there are alleged to be many such plans available in New York.

Equally inadequate, as I have seen them in operation, are the health and accident policies of the commercial insurance companies. Last week, for example, I filled out an insurance blank for a man with an income of $5,000 who had to have a major operation for cancer. He told me that the maximum cash indemnity he would get was $150. His hospital room, nurses' and surgeon's fees will run between two and three thousand dollars. Luckily he has some savings on which he can draw to take him through a long and terrible ordeal. So far as his insurance was concerned, the protection which is afforded him was illusory.

It is a pertinent and to my mind, an unfortunate fact, that virtually all the vountary health plans now in operation are supervised or even dominated by members of the medical profession. Consumer, employer or labor groups are scarcely represented. This may be one reason why they fall so woefully short of meeting the consumers' real needs; in any event, it is one of their major defects.

Because the voluntary plans in their present form seem to me so weak a structure I cannot see much merit in the legislation based on them; namely, the Taft bill (S. 1581), which seems an expression of the AMA viewpoint; or the Hill bill (S. 1456) which appears to me to embody the ideas of the Blue Cross-Blue Shield group. Considerably more promising, although I do not consider it wholly sound, is the Flanders-Ives-Herter proposal, S. 1970. This proposal embodies many of the excellent points of S. 1679. It eliminates the degrading means test, which the other measures require; it recognizes the need for a sliding scale of payments; it is designed to prevent medical domination of the voluntary health agencies; and it aims at providing comprehensive health care.

These are commendable provisions and the bill itself is a worth while effort to compromise conflicting points of view. Its weaknesses are those inherent in the system of voluntary health insurance on which it is based. To sum up, these are the unavoidable defects:

Voluntary health insurance, because it must be sold to the consumer, is inevitably costly.

Those who most need it are least likely to subscribe, because of their limited budgets.

Voluntary health insurance is not designed to provide comprehensive care including preventive medicine.

There is in the United States, among certain groups, a reluctance to study or learn by the experiences of other countries. This seems to be acutely true in the field of health. For there is abundant experience that other countries after trying voluntary plans have discovered that a national Government-sponsored plan is the only really efficient and satisfactory way of accomplishing the task. Despite this experience, we in this country, seem determined to learn the hard way, fumbling along step by step. That we will ultimately come to a national plan of health insurance, just as we have a national postal system, and a national social security system, I have no doubt. Possibly it is necessary for us as a Nation to travel the path via a number of devious routes, such as compromise half-voluntary plans, which do not seem so daring or alarming, at least to organized medicine. Personally, I am not alarmed; and I do not think the consumers of medical care would be in the least alarmed by a national health plan. The group I represent is strongly in favor of it. And I venture to suggest that you gentlemen could perhaps get a more complete picture of the Nation's needs and wishes from your constituents—particularly those who have not been in too good health—than from some of the so-called experts in this field. For, in fact, this is a problem so close to the American people that they themselves should be permitted to determine the solution.

I will be very glad to answer any questions you may have, Senator, or gentlemen.

Senator MURRAY. Doctor, I note that you have made some observations as to the so-called medically indigent group in the country. I understand your position is that that group is a very uncertain group.

Dr. SANDERS. Very elastic.

Senator MURRAY. A man may be perfectly able to meet all of his costs in connection with medical care, and eventually become medically indigent?

Dr. SANDERS. That is true, Senator. It all depends on the duration of the illness, and the cost of the illness.

Senator MURRAY. I understand that in New York City, they publish every year in the New York Times, a list of the 100 neediest cases for which they have taken collections for charity. Investigations of those 100 cases have been made on several occasions and they find that 90 percent of them are due to illness and to going into debt as a result of the costs of medical care which finally put them in the medically indigent class.

Dr. SANDERS. I read on the plane coming down today, a report from the New York Welfare Commissioner, in which he said 65 percent of those who are being taken care of by the city in his department, are in that condition due to illness. That quotation was from a magazine which the University of Michigan publishes.

Senator MURRAY. With reference to these voluntary programs around the country, my understanding has always been that they have such high requirements that people who need medical care most, find it impossible to join them because they are too expensive, or they are not acceptable because they are too great a risk for the plan.

Dr. SANDERS. Unless you took them in large groups, as in industry or a labor union, they become a great risk; and furthermore, the insurance company, be it the Blue Cross, or Group Hospitalization, or any of the other insurance companies, will investigate any individual and will not permit them to join the plan if they have any chronic illness or preexisting illness, or they will waive that and exclude that from their plan.

Senator MURRAY. And then, commercial insurance companies that insure people for health and accident, are very cautious about the character of people that they accept, in those insurance plans, are they not?

Dr. SANDERS. Senator Murray, I don't think we ought to consider the private insurance companies at all because those are for profit, and add on to their expenses in selling the thing, and so forth, and you have to add a profit on it. We don't really like to profit on the poor.

Senator MURRAY. I think you are absolutely right with reference to the insurance companies. I remember I held a policy of insurance for health and accident in a private company for about 25 or 30 years, and when I reached the age of 65 they canceled it on me and wouldn't carry me any longer because I became a risk.

Dr. SANDERS. I hold such a policy, and they asked me to exclude tonsillitis, because I had a couple of attacks of tonsillitis and they took that out.

Senator MURRAY. What do you think of the argument that is made by some that national health insurance programs would lower the quality of medical care? Is there any merit to that statement?

Dr. SANDERS. It would lower the quality?

On the contrary, I don't think it would lower the quality of medical care for the following reasons:

When a patient comes in to you now, and he is in the low economic group and you want to do a thorough study, say you want to do an X-ray of the gastroenteric tract, an electrocardiogram, blood chemistry studies, and so forth, on difficult cases, you have to think of the patient's pocketbook today, and you cannot give a thorough study because he cannot afford it. On the other hand, if we had a national health insurance program, you really could go ahead and do all the tests necessary to a proper scientific diagnosis, and therefore I say that the quality of the medical care would be improved rather than lowered.

Senator MURRAY. I think that is absolutely right.

Dr. SANDERS. And, the other point I would like to make is that doctors as a whole, have never paid much attention, on their wards in the hospital, to what they were paid. It seems to me that the best medical care that one sees is in the hospital where the doctor is not paid on the ward of the hospital, so that an argument that they would be paid inadequately, per capita, doesn't seem to me to hold good. I don't know whether I have made myself clear to you.

Senator MURRAY. Don't you think that the average doctor hesitates to put a patient to the high expenses that are necessary when he thinks that the patient is unable to pay, when he thinks that the person he is treating is a poor person with very little ability to pay? He will avoid a good many of the things that he should do in order to find out exactly what the condition of the patient is.

Dr. SANDERS. That was the point I tried to make.

Perhaps a person comes in and there is just a possibility that he has some serious illness, and it necessitates a $50 X-ray. You are going to say to yourself, "Why shouldn't I put that off? I may be all wrong about this." And, you don't take the picture.

Whereas, in a ward of a hospital where there is no financial aspect to the thing at all, or economic element, you would go ahead and take that X-ray picture to see whether the person had, say, cancer of the stomach or not.

Senator MURRAY. I think you are absolutely right, Doctor.

We have made great advances in medical care in this country in the last 40 years. Some of the people that are opposing this program seem to assume that all the advances have been made by the American Medical Association and that very little can be credited, or very little credit given, to any other reason why we have good health conditions in the United States.

Do you agree with that?

Dr. SANDERS. I would first like to say that I don't want to deprecate anything scientifically the AMA has done. They have done a relatively good job in specializing work, control of hospitals, intern education, and so forth; but, they neglect to tell you, when they quote the mortality and morbidity statistics, and infant mortality and maternal welfare and care statistics, that the same thing is going on in the poor countries in Europe; there is a steady decline because of a scientific knowledge which is pooled all over the world. We have contributed greatly to that world pool of scientific knowledge, but if you take the UN statistics now, and you compare the United States, there is a steady going down, but there is in every other country in the world also, the more civilized countries, certainly all the western democracies.

Senator MURRAY. And that scientific development has taken place to a considerable degree outside of the medical profession, the actual practice of medicine.

For instance, it has developed in laboratories where men are working on salaries; it has developed in medical schools and scientific establishments. They have discovered things that are of great value to the health of the people.

Dr. SANDERS. There have been great contributions made to medicine by laymen. The best example of that, of course, is Pasteur; and, another example is the physicists of the United States and the western democracies in their atomic work, the impact of which on medicine we don't yet understand; and, there have been very great contributions, it seems to me, made by all the allied sciences, but that is not to deprecate or run down the medical profession.

Senator MURRAY. That is right.

Dr. SANDERS. We will all grant that the medical profession in the United States is excellent.

Senator MURRAY. Surely.

Dr. SANDERS. The only thing we would like to do is make its excellence available to everybody.

Senator MURRAY. That is right. That is the main purpose of this proposed legislation.

Dr. SANDERS. That is the main purpose of it, as I see it.

Senator MURRAY. Thank you, Doctor, for giving us your time.

Dr. SANDERS. Thank you, sir.

Senator MURRAY. Dr. John J. Nugent.

Good morning, Doctor. Will you give your name and the organization you represent, for the records?

STATEMENT OF DR. JOHN J. NUGENT, DIRECTOR OF EDUCATION, NATIONAL CHIROPRACTIC ASSOCIATION

Dr. NUGENT. My name is John J. Nugent, and I am director of education of the National Chiropractic Association. My residence is in New Haven, Conn. I wish to express on behalf of the chiropractic profession and its institutions our profound appreciation for this opportunity of contributing to your consideration of Senate bills 1679, 1581, 1456, and 1106.

Unfortunately, the convention of our house of delegates will not be held until July, and our association has not had an opportunity to pass on these bills. However, our association has expressed itself on a bill similar to S. 1679 as follows:

> *Resolved*, That the executive board of directors of the National Chiropractic Association go on record as favoring the efforts of the President's committee to coordinate health and welfare activities, and recommend to our agencies and affiliated organizations that they give every cooperation to this committee in its efforts to bring about a better health service to our Nation.
>
> We further recommend that the committee always keep in mind the right of a citizen to choose his own doctor and method of healing and urge that the committee include doctors of chiropractic in the Federal health program.

The high purposes of these bills to assure adequate health services must inspire the support of everyone. It is, however, my purpose to urge upon you the desirability of considering such amendments to these bills as are necessary to insure real freedom of choice of doctor by the public.

Senate bill 1679, section 3, garantees to the public the "asured full freedom to choose their physicians and to change their choice as they may desire."

In numerous press releases sent out by Senators, Congressmen, and others favoring this bill, statements are made that the patient's freedom in choosing his own doctor is guaranteed. The words "doctor" and "physician" are used synonymously, and thus tend to confuse—if not mislead—the public.

Under existing State statutes regulating the healing arts, there are several kinds of doctors—medical doctors, chiropractic doctors, and osteopathic doctors. In some States these practitioners are also referred to as physicians.

It is obvious in this bill that the words "physician," "medical doctor," and "medical service" indicate that the framers of the bills were not using these terms in their generic meaning. It is also obvious that the intent of the bill is to restrict the choice of doctor to that of a medical doctor. The public, therefore, will not have, in fact, real freedom of choice of doctors. But will have only the freedom of choice between medical doctors and medical services.

The States, by legislative acts and referendums, have given their citizens fredom of choice of doctors by recognizing the professions of chiropractic and osteopathy. If this bill precludes the services of chiropractic and osteopathic doctors, if it restricts its benefits to medical services, it directly curtails by economic device the people's freedom of choice. By the same device it nullifies the privileges granted the professions of chiropractic and osteopathy by the States.

It may be argued academically that the bill does not do this, but actually it does. If a worker whose income is already taxed for medical care desires the services of a chiropractic or osteopathic doctor, he will be compelled to pay again. This amounts to double taxation. Faced with this predicament, it will not take him long to reach the conclusion that the economics of the situation leave him no freedom of choice of doctor, and that the freedom of choice which his State laws had granted him has been abolished.

I am not a lawyer nor an authority on constitutional law, but I believe there is a fundamental question of citizen rights here. I feel that the right of control over my own body and its care is somewhat closely allied to those other freedoms guaranteed by the Constitution. I believe that, subject to the reasonable exercise of the police power of the State, I should have the right to choose my own doctor and method of healing.

This bill, by its very emphasis on freedom of choice of doctors, recognizes that right. The States which, after careful consideration by the people, have licensed chiropractors and osteopaths also recognize that right. Are we then to have a complete negation of this principle by indirect legislation? Is this bill, when passed, to be a rescinding of those State rights by Federal legislation—by indirection—by Federal taxation?

We are in favor of the high objectives of this bill as set forth in its declaration of purpose. However, if the American Medical Association had written this bill, it could not have drawn more effectively, or with greater finesse, a measure to destroy the professions of chiropractic and osteopathy.

Senator MURRAY. I wish to assure, Doctor, that we had no help from the American Medical Association.

Dr. NUGENT. I didn't think so, but if it had been drawn by them, had they wished to destroy these two nonmedical professions, it could not have been drawn more completely.

Senator MURRAY. I understand, Doctor, and am very glad to have your criticism. That is what these hearings are for. We are glad to have you here, and I was trying to be a little facetious in assuring you that the American Medical Association did not give me any help whatsoever.

Dr. NUGENT. I was aware of that, sir.

As written, the bill will positively and inevitably destroy the property rights of some 30,000 men and women licensed to practice chiropractic and osteopathy.

Surveys have shown that some 30,000,000 people consult nonmedical doctors for their health needs. This bill would not only destroy the freedom of choice of this group but would deny that choice to the rest of our population.

Medicine, dentistry, dental hygienists, nurses, hospital administrators, and their auxiliary services are included in this bill. All the medical and allied professions are covered. Why is it that the framers of the bill omitted the nonmedical professions?

The nonmedical professions of chiropractic and osteopathy are licensed by the States under regulations similar to the licensure of the medical professions. They are subject to the same public-health regulations. The osteopathic profession is licensed in all States; the chiropractic profession in 44 States, the District of Columbio, Hawaii, and Alaska, and in all the Canadian Provinces except Quebec and the Maritimes. There are approximately 30,000 chiropractic and osteopathic practitioners, and there are approximately 6,000 students enrolled in 25 colleges at this date.

Who is responsible and what is the reason for the omission of these two internationally accepted and legally recognized professions? Is it because we constitute a minority group?

As I read the declaration of the exalted purposes of this bill, I am impressed by the statements that the bill will "assist qualified students: * * * without regard to race, color, or creed * * *" and that "* * * qualified individuals, particularly members of minority population groups * * *" shall be able to obtain adequate professional training. It is evident that the purpose is to remove the economic obstacles, the class distinctions, and the prejudices which have heretofore restricted entrance to the medical professions. Why then perpetrate a gross discrimination against two minority groups who through the years have struggled against the prejudice, discrimination, and open antagonism of the American Medical Association?

It is asserted that there is a critical shortage of physicians. Why then create a further shortage by wiping out some 30,000 qualified and licensed doctors of chiropractic and osteopathy?

What consistency is there in a measure which states that its purpose is to make available to all the public "the great promise of modern scientific knowledge and techniques" if it does not also make available the already acknowledged and established sciences and techniques of chiropractic and osteopathy?

The Federal Government as this moment is educating at its expense, under the Veterans' Administration, some 5,000 chiropractic and osteopathic students who after 4 to 6 years of study will be licensed as doctors by their respective States. They have a right to look forward to a life of service in their communities, and their communities have a right to their services.

What is to become of these veterans educated at Government expense if the professions for which they are trained are eliminated by the economics of this bill?

What is to become of some 25 chiropractic and osteopathic schools, with their faculties and equipment painfully built up through the years—not to mention the financial loss running into millions of dollars?

The answers to these questions are important to a minority group.

Thirty million people who believe in the efficiency of chiropractic and osteopathy constitute no mean minority, which is just as important as any other minority group in the country.

A preliminary survey for the committee on the cost of medical care made in 1928 showed that, while citizens of the United States spent some $850,000,000 for medical care, $105,000,000 was spent by this minority group for nonmedical care. If these amounts were paid in 1928, it is no exaggeration to estimate that they can be doubled or trebled for 1949.

The exclusion of chiropractic and osteopathic services from this bill ignores the contribution to public health by the nonmedical professions. This bill, if passed, will fix the pattern of health care for a Nation. It will, by taxation and its resultant economic pressure, impose its restricted form of treatment upon a large segment of the population.

I do not believe that the Federal Government may properly violate the convictions of its citizens in this respect, or take away, by indirect legislation, their freedom of choice of doctor or form of healing guaranteed to them by State laws.

The Federal Government might just as well tell the people of the United States that they should have more and better spiritual guidance; that they shall pay for it out of their own pockets but that they may have only the kind prescribed by the Federal Government.

All that I have stated concerning Senate bill 1679 applies with equal force to Senate bills 1581, 1456, and 1106.

Therefore, gentlemen, for all these reasons, we respectfully urge upon you the necessity of spelling out by affirmative language in the bills the intent of Congress as to freedom of choice of doctor beyond any possibility of future error or administrative caprice.

Senator MURRAY. Thank you, Doctor.

I would like to ask you: How is your profession affected by the present voluntary insurance systems?

Dr. NUGENT. Under the present voluntary plans, in some localities the chiropractor is paid for his services; in other communities, he is not. It depends a good deal on the whim or caprice of the local administration.

Senator MURRAY. At the time a person joins a voluntary system, do they have to then specify whether or not they would need the services of a chiropractor or an osteopath?

Dr. NUGENT. No, sir. The plan usually specifies medical services, and then it is a fight after that.

Senator MURRAY. Then, a person insured under that system would have a right to elect to have the services of a chiropractor or an osteopath?

Dr. NUGENT. I don't think so. Generally speaking, no, sir. It is usually a battle.

Senator MURRAY. With some few exceptions, they do allow it?

Dr. NUGENT. Yes, sir, I have heard of cases——

Senator MURRAY. And that is what you are objecting to? You want any system, whether compulsory or voluntary, to protect other legitimate professions and those that are licensed to practice those professions?

Dr. NUGENT. That is right, sir. I want you to understand that we are not opposing the bill. We are simply calling your attention to what we consider was an oversight.

I would like to say, incidentally, the question came to my attention, it never occurred to me, but it came to my attention in the last few hours that some might be of the opinion, or under the impression that because chiropractors or osteopaths, if they were included in this bill, that it would change their status, the status of their practice in the States. It would not do that, of course; because we assume that under the benefits of this bill the patient would be entitled to just as much privileges as the States granted the practitioner. In other words, the practitioner went out to practice within the scope of his practice as defined by State law.

The question one time was raised as to whether the inclusion of these two professions, the so-called nonmedical professions, would increase the cost as estimated for the purposes of this bill. It would not, sir, because I assume that those who estimated costs of care for the population, for the entire population of the country, they figured on the entire population which I understand is some 147,000,000 people, now.

An individual, myself for example, tomorrow I might need surgical care, I might need medical care, depending on my condition. The next day I might need chiropractic or osteopathic care. The costs of medical care certainly would include the costs of any care that I might receive at the hands of an osteopath or chiropractor, so that I am of the opinion that the total estimated cost of granting medical services to the entire population would include those services.

Senator MURRAY. There are many instances where people are in a state of health that requires care, and where they do not actually need medicine, but where some physical manipulations or electric treatments and so forth would be beneficial.

Dr. NUGENT. I might have sprained my back, in my work.

Senator MURRAY. Did the Army, during the recent war, recognize that? Did they employ people for that kind of service?

Dr. NUGENT. The Army Medical Corps, of course, which is governed under the jurisdiction of the Surgeons General of the Army and Navy, who are medical men, of course refused to recognize the practice of chiropractic or osteopathy in the services.

Senator MURRAY. Did they employ men though, without recognizing them—they have used some of their processes.

Dr. NUGENT. Yes, sir, they did. We have many examples of that.

Senator MURRAY. Didn't they use men like those that work on their feet——

Dr. NUGENT. Chiropodists?

Senator MURRAY. And there is another profession, podiatry.

Dr. NUGENT. They are now known as podiatrists. They have changed their name recently.

Senator MURRAY. There was something that was recognized in the Army as very important, was it not?

Dr. NUGENT. As a matter of fact, strange as it may seem, Senator, they were recognized in the Navy but not in the Army.

Senator MURRAY. Is that so?

Dr. NUGENT. Yes, sir. You would think ordinarily it would be just the reverse. A soldier walks on his feet; but, they didn't recognize them in the Army but they did in the Navy.

I think, Senator, that when some consideration is given to these professions which are recognized throughout the country, and with the great number of people that are consulting these professions of chiropractic and osteopathy for health care, I think that the committee will inevitably come to the conclusion that the benefits of these professions should be granted to the people in the country under this bill.

Senator MURRAY. Well, I am very glad to have had your testimony here this morning, Doctor.

Thank you, very much.

Dr. NUGENT. Thank you, sir.

Senator MURRAY. The next witness is Wilma L. West.

STATEMENT OF WILMA L. WEST, EXECUTIVE DIRECTOR OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Senator MURRAY. State your full name and the organization which you represent this morning.

Miss WEST. Yes, sir. I am Wilma L. West, executive director of the American Occupational Therapy Association, and I am the official representative of that association this morning.

Senator Murray, may I ask if it is the pleasure of the committee to have this testimony read?

Senator MURRAY. If you wish, we would like to have you summarize it and the entire statement will be incorporated in the record, if you wish to do it that way, that will be satisfactory.

Miss WEST. This testimony, and our appearance here this morning is with reference to title I, part A, of Senate bill 1679, and of similar parts and titles of the other omnibus health bills which are concerned with education of health personnel.

Briefly our case is founded on the reasons which I assume prompted the writing of these parts of these bills, namely, a recognition of the shortage of certain groups of medical personnel.

Senator MURRAY. Will you give us a short definition of "occupational therapy"?

Miss WEST. Occupational therapy is treatment through activity. It uses certain manual activities, arts and skills for their therapeutic affect in all types of illness and disability. It has a broad psychological basis of existence in recognition of the fact that the occupied mind is a healthier one than the idle one; and, in addition to that, it is used in a more scientific way today than formerly in that certain physical therapeutic benefits from exercise are derived from activities by the patient.

As a profession, we are fairly young, having been organized in the First World War and having grown steadily but rather slowly up until the Second World War. At that time, the extension of the use of our services to the Army and Navy hospitals used up the very small reservoirs of personnel.

Until 1940 we had only five training schools in the entire country. At that date we also had only a total of 631 trained occupational therapists.

In the period of the war years we expanded from 5 to 25 schools, and from 600 to 3,600 trained personnel.

That seems like a relatively remarkable growth over a short period of time, but the use of the personnel by a larger number of agencies today, by all Army, Navy, Public Health Service, and Veterans' Administration hospitals, and increasingly by civilian community rehabilitation workshops and centers and by new fields such as the care of the aged, which are coming along in increasing importance, have usurped all the available personnel.

The training is somewhat long and extensive. It is not available to a large number of persons to fill the present need for their services, and our statement therefore is in request of your consideration of including our profession among other medical and similar groups which are to be benefited through scholarships to students in order that the training will be available to larger numbers, and financial aid to schools to help them extend training facilities to make that possible.

I think that about covers it.

Senator MURRAY. Would you give us an illustration of some case where you have practiced your profession and brought results?

Miss WEST. You mean, an exact medical case where it has been used?

Senator MURRAY. Yes, where your assistance has been used. Give us an example.

Miss WEST. I might cite a case of a fractured arm, which is, of course, immobilized in a cast for a certain period of time.

Senator MURRAY. Yes?

Miss WEST. Perhaps the fingers are free of the cast while it is immobilized. These free fingers must be kept somewhat mobile and active while the bones are setting in the upper arm. Occupational therapy is prescribed for this purpose, in the use of bilateral activity where the use of both hands is also prescribed for psychological benefit, for encouraging activity and interest in something besides intraversion and concern with one's illness and what is the matter with them.

When the cast is taken off, naturally the arm is stiff from having been still for a long period of time, and the muscles have wasted away from not being used. Exercise is prescribed by a doctor and carried out by the patient under the supervision of the therapist to both increase the range of motion and muscle strain, so that there are the dual purposes or the psychological and physical effect of exercise.

Senator MURRAY. Does your profession aid the paraplegics in the veterans' hospitals?

Miss WEST. Yes, sir. There is occupational therapy on every paraplegic service in the veterans' hospitals.

Senator MURRAY. Thank you for your testimony. Your entire statement will be printed in the record in connection with the testimony.

(The statement is as follows:)

STATEMENT OF WILMA L. WEST, EXECUTIVE DIRECTOR, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

The American Occupational Therapy Association has requested the privilege of presenting to the Senate Committee on Labor and Public Welfare information relative to occupational therapy services and the necessity of providing for such services in health measures concerned with the total rehabilitation of the sick and disabled.

1. THE ROLE OF OCCUPATIONAL THERAPY IN THE HEALTH PROGRAM

Occupational therapy has long been recognized as an important phase of medical treatment. Through the use of medically prescribed activities it contributes to both mental and physical readjustment and thus to restoration and rehabilitation of the patient. The therapeutic skills of the occupational therapist complement and are coordinated with the efforts of the physician, nurse, physical therapist, social worker and a number of other auxiliary medical workers. In administering treatment prescribed by the physician, the occupational therapist uses a wide range of skills, such as woodworking, plastics, metal work, printing, ceramics, educational subjects, and recreational and prevocational activities.

The particular disability determines the application of these activities as treatment for the various mental and physical conditions. Occupational therapy may be prescribed for specific restoration of muscle and joint function as in cases of fractures, burns, amputations and paralyses resulting from disease and accidents; for the development of general physical strength and work tolerance as in cases of tuberculosis, heart disease, and other long-term illnesses; for emotional readjustment and as a diagnostic aid in various mental disorders; for prevocational exploration in the convalescent stage of all illnesses; and for aiding adjustment to hospitalization and disability. Whatever the disability, the particular need of the patient, as in all medical treatment, is the prime consideration of the occupational therapist who is trained to evaluate the physical, emotional, social, and vocational factors inherent in the various conditions, and thus is able to treat the patient as a whole.

2. DEVELOPMENT TO DATE AND PRESENT NEED

Established as a profession in 1917, occupational therapy was developed to meet the needs of the war injured. Since that time it has grown steadily and proved its value as a necessary adjunct to medicine. As a result of the expansion of occupational therapy, first in Army and Navy hospitals during World War II, and more recently in Veterans' Administration, Public Health Service hospitals and other types of public institutions, it has become impossible to meet the demands for qualified occupational therapists.

Statistics obtained from the principal services which use occupational therapy today reveal the following deficiencies in the numbers of personnel needed:

State institutions	3,000
Army, Navy, Public Health Service, and Veterans' Administration	1,000
Private institutions	1,500
Crippled children's services	500
Total	6,000

The above figures are based on actual present need only and do not include the numbers which are required to effect the much-needed development and expansion of present services. For example, at a recent meeting of psychiatric hospital administrators, it was stated that 12,000 occupational therapists would be needed with the expansion necessary to provide adequate treatment for the Nation's mentally ill. It has also been said that 10,000 occupational therapists are needed for the expansion of services to the physically disabled.

Approximately 60 percent of the total number of active occupational therapists are currently employed by institutions which receive part or all of their support from public funds.

The following figures point up the growth in numbers of trained personnel during the present decade:

TRAINED OCCUPATIONAL THERAPISTS

1940	631	1949	3,627
1945	1,872	1950 (estimated)	4,000+

As indicated by the above figures, graduates of accredited schools have steadily increased in number during the current decade. However, the attrition rate, which is from 6 to 10 percent annually, has reduced the active working force to less than two-thirds of the number trained, or a total of only 2,100 practicing occupational therapists. The employment of large numbers of this personnel by the Army, Navy, Public Health Service, and Veterans' Administration, none of which employed any appreciable numbers prior to World War II, has absorbed most of the available personnel. It is therefore evident that the supply is totally inadequate to the demand.

3. FACILITIES FOR TRAINING IN OCCUPATIONAL THERAPY

There are 25 schools of occupational therapy accredited by the council on medical education and hospitals of the American Medical Association. Twenty of these have been established since 1941. The total capacity of these schools is approximately 2,300; at present, however, only 1,700 students are enrolled. Existing training vacancies are accounted for by a natural retrenchment following expansion during the war, when Government-subsidized courses made training possible for larger numbers. With this support removed, and no other funds supplied for scholarships, the greatly increased number of schools have not in the postwar years been able to maintain enrollment capacities.

4. PROFESSIONAL TRAINING

The council on medical education and hospitals of the American Medical Association has established "essentials of an acceptable school of occupational therapy." These essentials form the basic approved requirements for training.

The professional ocupational-therapy curriculum, starting on a college junior-year level, covers approximately 3 years, consisting of a minimum of 60 semester hours of academic work and 9 months of practice training. Thirty of the 60 semester hours are devoted to sciences such as anatomy, psysiology, neurology, psychiatry, and sociology; clinical subjects covering general medical and surgical conditions, orthopedics, tuberculosis, and cardiac diseases; and courses interpreting the principles and practice of occupational therapy in pediatrics, psychiatry, tuberculosis, orthopedic and general medicine and surgery. The remaining 30 semester hours include technical instruction in manual activities, arts and crafts, educational subjects, and recreational activities. The required 9 months of hospital practice follows this training. Clinical affiliations for this purpose are arranged to include experience in children's, orthopedic, general, mental, and tuberculosis hospitals.

5. STAFF AND PLANT

Schools of occupational therapy are affiliated with or are a part of colleges or universities of recognized standing. Committees acting in an advisory capacity to the director of the occupational-therapy school represent the departments of the college or university which participate or cooperate in the teaching of occupational therapy.

The schools have teaching staffs graded and organized by departments. The staff includes, among its regular salaried instructors, an administrator or coordinator who is a registered occupational therapist employed on a full-time basis. In addition, one or more assistant occupational therapists are usually employed for administrative or teaching duties. The majority of instructors are those employed by other departments of the college or university.

The physical plant usually provides only the minimum in lecture rooms, class laboratories, library, administrative offices, and equipment essential to teaching the prescribed courses.

6. COST OF TRAINING

It is estimated that the average cost of training an occupational therapy student is from $1,000 to $1,200 per year. With the average tuition at $264, only 20 to 30 percent of the total costs of training are paid by tuition.

7. NEED FOR AID

Every indication points to a need for many times the number of occupational therapists that is being trained today. To prevent expansion at the expense of standards, two types of aid are essential.

First, schools of occupational therapy need funds for three main purposes: Faculty and staff, physical plant, and clinical training. These funds could be used both to increase salaries of existing staff, thereby improving the caliber of teaching personnel that could be attracted; to employ much-needed additional help as most of the schools are understaffed; and to improve or extend training facilities in hospitals and rehabilitation centers to which students are assigned for clinical practice.

Secondly, aid is needed in the form of scholarships to enable larger numbers of students to undertake training. Through an intensive publicity and recruitment program currently being conducted by the American Occupational Therapy Association, it is hoped that more potential candidates may be enrolled in the next few years and existing facilities expanded or new ones developed to more nearly meet the need. However, it is increasingly apparent that professional training, which must be preceded by a minimum of 2 years general education, is beyond the financial means of many qualified and highly desirable candidates. The cost of training, in other words, is such that many of the best prospective students are unable to assume it. This fact considerably limits the field of potential recruits. A further handicap to recruiting will be felt if similar professional fields are subsidized while the costs of training for occupational therapy remain the same or, as is the case in several instances, are increased in order to compensate for rising educational costs in general. Scholarships covering tuition, books, and supplies and $125 per month for maintenance would greatly relieve this problem.

8. SUMMARY

The occupational therapist is an important member of the medical team concerned with the total rehabilitation of the sick and disabled. Her therapeutic skills are used in close correlation with those of the doctor, nurse, physical therapist, social worker, and other auxiliary medical personnel.

Given great impetus by increased use during World War II, occupational therapy is now in extensive use in Army, Navy, Veterans' Administration, and Public Health Service hospitals as well as many other types of public and private institutions. Present needs, exclusive of expansion, are for nearly double the present numbers of trained personnel. Existing schools are not filled to capacity because of the withdrawal, after the war, of Government and other subsidies which had greatly expanded training facilities.

The professional education of an occupational therapist, as defined by the American Medical Association, requires a minimum of 3 years, preceded by 2 years of college. Two years' study of biologic and social sciences, clinical subjects, and the theory of occupational therapy comprise the theoretical training which is supplemented by technical instruction in the arts and crafts which are the treatment media of the occupational therapist. A minimum of 9 months of hospital-practice training in the fields of orthopedics, psychiatry, pediatrics, tuberculosis, and general medicine and surgery is also required for completion of the program.

Schools of occupational therapy are connected with colleges and universities and operate under the guidance of advisory committees. The director is a registered occupational therapist assisted by other administrative and teaching personnel.

Of the total average cost of $1,000 to $1,200 for training per student per year, only 20 to 30 percent is paid by tuition. Additional funds are needed by schools for faculty and staff, physical plant, and clinical affiliations. Since the cost of training for this profession is beyond the means of many, scholarships would increase enrollment which in turn would produce greater numbers of trained personnel to meet ever-increasing needs.

9. CONCLUSIONS

The foregoing statement points up the need for financial subsidy of occupational therapy training. This need is of somewhat recent origin, dating primarily from the war years, and is caused by an unprecedented expansion of the demand for occupational therapy services. It is, however, a need which, in view of current developments in health programs, will continue and increase in the near future.

Regardless of the type of legislation considered to provide aid for education of medical personnel, occupational therapy should be included with other auxiliary fields. In the broadened concept of rehabilitation, it makes a vital contribution to the total treatment program of the sick and disabled.

Senator MURRAY. Mildred Elson is our next witness.

STATEMENT OF MILDRED ELSON, EXECUTIVE SECRETARY, THE AMERICAN PHYSICAL THERAPY ASSOCIATION

Senator MURRAY. Will you state your full name and the organization you represent, please?

Miss ELSON. Yes, sir.

I am Mildred Elson, executive secretary of the American Physical Therapy Association, the professional organization of physical therapists composed of 3,935 members in 51 chapters in the various States and territories of the United States and the District of Columbia. National headquarters are at 1790 Broadway, New York City.

The association requested the opportunity to appear before this committee in reference to title I, part A, Education of Health Personnel, S. 1679, and for any other bill which might be considered and which refers to education of health personnel.

Physical therapy is a medical-auxiliary service, and an essential part of medical rehabilitation, prescribed by a licensed physician and administered by a qualified physical therapist to help restore the physically handicapped patient to useful living.

I might do the same thing that Miss West has done. I don't believe my whole statement needs to be read, since it is going into the record.

Senator MURRAY. The entire statement will be carried in the record, but if you wish to we will be glad to have you summarize it.

Miss ELSON. I can state what physical therapy is. I will use the more or less dictionary definition in telling you what it is.

It is the employment of physical and other effective properties of ultraviolet light, infrared radiant energy, heat, cold, water, electricity, therapeutic exercise, and massage and treatment of disease and injury for diagnostic tests.

In my statement, I have gone into it more fully; that is, as to some of the examples of what we do.

We also wish to point out the need for physical therapists. We have had a similar growth to the occupational therapists. Physical therapy was born in World War I and developed slowly through the years, and reached its impetus in World War II. At the beginning of 1941, we had 1,400 physical therapists in the United States. At present there ars 4,000. During the war period, our growth was rapid and there were 1,600 physical therapists in the services of their country, with the major portion in the Army.

We know, from the figures, of the number of physically handicapped, and I realize those are not accurate, what the problem is, and I might briefly review some of those figures.

In a survey conducted by the National Health Service, and this is on page 3, 800,000 families in 83 cities and 23 rural areas of 19 States were studied. The reliability of this study had been demonstrated in other selective samples on the extent of chronic disability. From this survey it was estimated that there are some 23,000,000 persons in this Nation who at that time were handicapped to some extent by disease, accident, maladjustment, or former wars. That number has undoubtedly increased due to disability suffered directly in the war or indirectly through increased industrial activity associated with the war.

In thinking of the handicapped, the average citizen is inclined to think solely of disabled veterans, yet the extent of physical disability among our civilian population is far greater. For example, the number of persons permanently disabled in farm accidents in 1945 was four times greater than the number of servicemen permanently disabled in the bloody assault on Iwo Jima. During the period between Pearl Harbor and VJ-day, 20,500 servicemen underwent amputations, but in the same 4 years, over 120,000 civilians suffered major amputations as the result of accident and disease.

In addition to that, we have better than 300,000 suffering from cerebral palsy, a like number from the residual effects of infantile paralysis, and last year we had over 27,000 cases of infantile paralysis, and this constituted a real problem, and we anticipate an even greater one this year because the infantile paralysis is striking in areas where we have no physical therapists. Last year 222 were recruited from various sections of the country to go into those sections where it was severe and where there were no or insufficient personnel.

There are 26 schools—and I am not reading from the statement now—of physical therapy in the United States at present. Their capacity is about 417. At our peak, during the war, it was about double that number; and, in questioning the improved status, recently it was estimated that they could double their capacity very quickly if there were financial aid to increase their physical plan to provide for more teachers in order that they could take care of the expanded load.

Most of them, after the war, dropped down from their acceleration because they felt that possibly the need was not going to be so great; but, on the contrary, the use was found to be even greater.

Now, then, it was during the war that the doctors saw the need of this service.

The cost is great. The length of the professional course is from 12 to 18 months. The average tuition is about $450. We estimate that pays about a third of the tuition. The maintenance is usual for all students.

The association would like to request that consideration be given to this group for aid to the approved schools and courses of physical therapy, and for stipends to students from any general fund of education under S. 1679 or other bills.

Senator MURRAY. Thank you very much for your statement. The matter will be given very careful consideration by the committee.

(The statement is as follows:)

STATEMENT OF MILDRED ELSON, EXECUTIVE SECRETARY FOR THE AMERICAN PHYSICAL THERAPY ASSOCIATION

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The association requested the opportunity to appear before this committee in reference to title 1, part A, Education of Health Personnel, S. 1679, and for any other bill which might be considered and which refers to education of health personnel.

Physical therapy is a medical auxiliary service, an essential part of medical rehabilitation, prescribed by a licensed physcian and administered by a qualified physical therapist to help restore the physically handicapped patient to useful living.

Physical therapy, as the name implies, is treatment by physical means. It is one of the earliest forms of medicine—in fact it was described by Hippocrates. All of us are familiar with some of the procedures but possibly not in their application to specific conditions or injury. Heat for example is widely used for relief of pain. However, in many conditions heat may not be desirable—it may actually be harmful. The physician prescribes definite forms of heat, indicates the amount and the intensity. The physical therapist must be familiar with all the different methods of applying heat as well as the conditions being treated. Heat may be applied by special lamps, diathermy, hot water as in whirlpool baths and hot paraffin. If the patient reacts unfavorably to heat, the physical therapist has been trained to observe these reactions and to report immediately to the physician thus safeguarding the welfare of the patient.

Massage is not just rubbing but is a skilled procedure with many different techniques which are prescribed to obtain definite results. It may be to only one muscle or to scar tissue to soften and stretch it. A leg which is paralyzed needs specific massage to improve circulation in order that muscles may obtain needed nutrition from a fresh blood supply. Heavy rubbing by the unskilled may permanently injure these remaining threads of muscles and thus defeat the purpose of treatment which is therapeutic or curative.

EXERCISE

All normal people exercise to keep fit. An office worker may say what I need is a good game of golf or a workout in the gymnasium which is a healthy instinctive reaction. The handicapped also needs exercise but general exercise is beyond his capacities. He may have an imbalance of muscle power—some strong, some weak—such as in polio or a paraplegia (paralysis from a spinal injury). Obviously the weak muscles need special or therapeutic exercise. First a detailed muscle test must be given to find out what he has left, which muscles are strong and which are weak. He may not be able to straighten his knee against gravity. To the untrained this would mean a total loss. The physical therapist by placing the patient in a different position in which the movement is made easier finds there is some life left in the muscle. Through careful muscle reeducation this muscle may be strengthened sufficiently so that when the patient stands his knee does not buckle. Therefore a brace may not be necessary. Exercise for the handicapped must be therapeutic and tailored to his particular needs. The type of therapeutic exercise for a cerebral palsy patient, one who has no control over his muscles, is very different from that given to an infantile paralysis patient. The tight spastic muscles must be relaxed. Control must be taught to reestablish as near normal function as is possible.

The purpose of therapeutic exercise is to obtain maximum strength and control in order that the patient may live with what he has left. Many must be taught to walk with braces, crutches, or with an artificial leg; to get from the bed to the wheel chair to a regular chair; to open doors; to feed themselves, brush their teeth, or in other words to do all the everyday activities which normal people take for granted. All this is therapeutic exercise.

THE EXTENT OF THE NEED

There are no accurate figures available on the total number of physically handicapper persons in the United States. The most comprehensive source of information at present is the National Health Survey conducted by the United States Public Health Service in 1935–36. In this survey, 800,000 families in 83 cities and 23 rural areas of 19 States were studied. The reliability of this study has been demonstrated in other selective samples on the extent of chronic disability. From this survey it was estimated that there are some 23,000,000 persons in this Nation who at that time were handicapped to some extent by disease, accident, maladjustment, or former wars. That number has undoubtedly increased due to disability suffered directly in the war or indirectly through the increased industrial activity associated with the war.

In thinking of the handicapped, the average citizen is inclined to think solely of disabled veterans, yet the extent of physical disability among our civilian population is far greater. For example, the number of persons permanently disabled in farm accidents in 1945, was four times greater than the number of servicemen permanently disabled in the bloody assault in Iwo Jima. During the period between Pearl Harbor and VJ-day, 20,500 servicemen underwent amputations, but in the same 4 years, over 120,000 civilians suffered major amputations as a result of accident and disease. Ignoring the vast number of persons who suffer disabilities resulting from disease each year in this Nation nearly 50 percent more persons are permanently disabled from accidents alone than there were American servicemen disabled as a result of combat during the entire 4 years of the war.

Added to these are the 6,850,000 persons who suffer from rheumatism and arthritis; the 300,000 from cerebral palsy and a like number from the residual effects of poliomyelitis; the 400,000 who have undergone major amputations and the thousands of others who suffer from multiple sclerosis and other chronic neurological disorders. Physical therapy is a recognized and needed form of medical treatment for the great majority of these cases if they are to be productive citizens. Yet we have in this Nation at present approximately 4,000 qualified physical therapists to meet this staggering need.

Last year in the United States, there were 27,484 cases of infantile paralysis reported by the United States Public Health Service. Some 222 physical therapists were recruited by the National Foundation for Infantile Paralysis to go into those sections of the country where the epidemic was most severe and where there were no or insufficient physical therapists available. This was actually robbing Peter to pay Paul for by this means we are not adding more physical therapists but are only shifting them from one place to another and thus someone goes without treatment.

The National Foundation for Infantile Paralysis has since 1942 provided scholarships, teaching fellowships, and financial assistance to the approved schools at a cost of $2,292,215. Scholarships were awarded to 1,127 applicants without regard to race, color, creed or religion.

In the same period the Medical Department of the Army trained 1,079. A considerable number had their training financed by State crippled children's agencies through grant-in-aid programs of the Children's Bureau. Others since 1945 have received their professional training under the GI bill of rights. It is estimated that approximately 65 percent of those trained since 1942 have received full or partial financial assistance in obtaining their professional education.

In 1941 there were but 1.400 physical therapists in the United States; in 1945, 2.900. It is of interest to note that over 1,600 of these were in the service of their country with the greatest number in the Army. In 1949 there are approximately 4,000, which is about three times the number available in 1941.

These physical therapists are employed throughout the country in hospitals of the Veterans' Administration, United States Public Health Service, Army, Navy, and Department of the Interior; in State, county and voluntary hospitals, crippled children's schools, rehabilitation centers, convalescent homes, and State services for crippled children and other public health agencies.

There is an immediate need as we see it for a minimum of 1,500 physical therapists over and above those now available. Four hundred and seventeen will be graduated this year. Requests for physical therapists come in from all over the country. All emphasize the urgency of their needs. For example:

A hospital in Texas has 57 new polios and no physical therapist. A minimum of 4 are needed as the average case load of a physical therapist is 15 to 20 and if severely disabled, the maximum is 8 to 10 patients per day.

In West Virginia the consultant for State services to crippled children writes: "I continue to hold the fort alone, attempting to give field services to 500 children, attend 7 monthly State crippled children's clinics and service 2 Saturday cerebral palsy treatment centers per month. I fully realize adequate service cannot be given so many by a lone physical therapist. We have wonderful cooperation from the doctors and they are all interested in physical therapy. This is shown by an increase of 225 in the case load in the last year and a half."

From Kansas City, Mo., a physician writes: "I am interested in hearing from any qualified physical therapists who would be interested in working in cerebral palsy. We have plans for expansion of my own work in Kansas City and St. Louis and in our clinics at St. Joseph, Springfield, and Joplin which are sponsored by the Missouri Society for Crippled Children." This request has been unfilled since November 1948.

These are but three of the many unfilled requests.

The shortage of personnel has been recognized by all medical groups including the American Physical Therapy Association. One of the chief reasons for the shortage is the increased use of physical therapy. World War II demonstrated its effectiveness in the treatment of those disabled in combat or by accident. Physicians now wish to make it available to the thousands of civilians who are disabled. Until recently only a token amount of physical therapy was available to cerebral palsy patients as it was felt that the condition was hopeless and untreatable. In the years 1946–47 and 48 there were 63,916 cases of polio. A recruitment program has been and is being carried on by the American Physical Therapy Association with the assistance of such voluntary organizations as the National Foundation for Infantile Paralysis and the National Society for Crippled Children and Adults. The 26 approved physical therapy schools have almost capacity enrollment. There were but 42 vacancies reported in schools for the past academic year. Of the 417 students who were enrolled in approved schools last year, 183 were receiving scholarship assistance from the National Foundation for Infantile Paralysis. If those stipends were withdrawn plus financial aid to the schools, enrollment would drop sharply since the cost of the professional education cannot be met by the average student.

PHYSICAL THERAPY EDUCATION

The average length of the professional course is 12 to 18 months. Students entering schools of physical therapy must have completed one of the following: a minimum of 2 years of college with appropriate science courses; graduation from a school of nursing; or graduation from a school of physical education. All approved schools and courses must meet the minimum curriculum and other requirements of the council on medical education and hospitals of the American Medical Association. The course of study includes anatomy with emphasis on muscles and their action, physiology, pathology, neuroanatomy, psychology, physics and the application of physical therapy to diseases and injuries. The student, in addition, must be thoroughly skilled in muscle testing, muscle reeducation and all other forms of therapeutic exercise; therapeutic massage; in the application of all forms of heat as well as many other procedures which are prescribed in the treatment of the physically handicapped.

THE COST OF PHYSICAL THERAPY EDUCATION

Accurate figures on the cost of professional physical therapy training are not obtainable because the schools and courses are not administered independently but are a part of or affiliated with a university, medical school, or hospital. In some schools instructors are available without direct costs to the physical therapy schools since they are full-time salaried personnel on the general budget of the university or college. Others may be charged with an hourly rate of instruction dependent upon the instructor's academic rank. In general, it is estimated that moneys received from tuition pay an average of one-third of the total cost of instruction.

One example: A university physical-therapy course with 16 students has estimated that $18,700 is paid out for instruction and administration. Equipment needed for instruction is valued at $15,000. This equipment, however, is not used exclusively for teaching purposes. No amount is charged for space used or other maintenance needs. Tuition for this course is $450. Maintenance for the student averages $100 to $125 per month. Books, laboratory fees, and uniforms averaged from $100 to $150 per year.

CONCLUSION

It is a recognized premise that any medical service is dependent upon personnel, not only the number but equally important the quality. In physical therapy the number available is insufficient; the quality of those available is high. Standards have been maintained and during the war years when the demand for more physical therapists was equally urgent, there was no lowering of standards since it would have affected those who needed it—the war wounded. A single voluntary agency has contributed the most in the past few years in providing for more physical therapists, through scholarships to students as well as financial aid to schools. This has been good but with the increased demands and awareness of the potentialities of physical therapy in the physical rehabiltation of the handicapped it is not enough. It is felt that the demand for more physical therapists can be met through expansion of teaching facilities and increased instructional staff, both academic and clinical, which would permit larger enrollment. Expansion must not be undertaken at the expense of existing standards, any lowering of which would be detrimental to the welfare of the patient. All schools and courses should be affiliated with a medical school and have competent medical guidance since physical therapy is a medical auxiliary service.

It is therefore requested that consideration be given to providing financial aid to schools and courses of physical therapy and for stipends to the students from a general fund for education of health personnel in this or in any other bill which carries this provision.

Senator MURRAY. That concludes the witnesses for this morning.

We will now adjourn until 10 o'clock tomorrow morning.

(Whereupon, at 11:55 a. m., the hearing was adjourned until the following morning, Wednesday, June 22, 1949, at 10 a. m.)

NATIONAL HEALTH PROGRAM OF 1949

WEDNESDAY, JUNE 22, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10:05 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray and Donnell.

Senator Murray. The hearing will come to order, please.

The first witness this morning is Dr. Bernard C. Meyer, of the Physicians Forum, New York.

Dr. Meyer?

STATEMENT OF DR. BERNARD C. MEYER, ON BEHALF OF THE PHYSICIANS FORUM

Dr. Meyer. Mr. Chairman, I speak for the Physicians Forum, a national organization of physicians all of whom are members either of the American Medical Association or of the National Medical Association, interested in studying methods for the improvement and wider distribution of medical care.

As physicians, we are aware of the great need for ready access to full medical facilities for those who cannot afford to buy medical care; but we are equally concerned to make sure that any measures that may be instituted will assure that this medical care be of the best; not alone that the quality of care should not deterioriate, but that it should be improved.

Despite the claim of their proponents of a rapid growth of voluntary health insurance, now estimated to cover 55,000,000 individuals, it should be emphasized that with few exceptions, voluntary health-insurance plans do not offer comprehensive coverage of medical needs. Benefits are restricted to hospitalization and the cost of operations, and certain professional expenses when the patient is in the hospital. The allegation that these same 55,000,000 individuals are protected by 80,000,000 policies emphasizes the inadequacy of coverage of most single policies. Moreover the income limits set for subscribers entitled to service benefits are so low that voluntary medical-care insurance actually becomes a cash indemnity plan, offering only partial protection. Even among the more comprehensive voluntary plans, subscribers today are protected on the average for only 35 percent of their annual sickness bill. The cost of most illnesses is not included, and there is no provision for preventive services, and no encouragement for the patient to visit the doctor at the first sign of illness. The rates for premiums are usually fixed and not proportional to income. Thus, these plans do not offer any fundamental solution to the problem of providing good medical care.

In many States the medical societies have succeeded in having laws passed that give them a monopoly in setting up health-insurance plans, and which prevent cooperatives and other community groups from establishing their own health plans.

The set-up of most voluntary health-insurance plans sharpens the cleavage between preventive and curative medicine at a time when the changing face of disease, induced by the efficient control of the infectious diseases, has brought about a reorientation of public health activities.

The bill, S. 1456——

Senator DONNELL. Might I ask, I notice you left out in reading the sentence with respect to the so-called chronic degenerative diseases today—did you intend to leave that out?

Dr. MEYER. I am reading an abstract.

Senator MURRAY. Not the full statement?

Senator DONNELL. I would like, Mr. Chairman, that the record might show at this point that in his complete statement, and which he did not read, occurred the sentence:

> The so-called chronic degenerative diseases today are the major health problem, and none of the conventional methods of preventive medicine will ward off any of these disorders.

Is that your present judgment?

Dr. MEYER. Yes, sir; that is our present judgment.

Now, as to S. 1456:

This bill proposes to provide hospital and medical care to those unable to pay all or part of the costs by giving them service cards which will entitle them to services from a voluntary health-insurance plan. Grants-in-aid are made to the States, and these set up State agencies which are to administer the plan. The provision for medical care is very incomplete, omitting the services of the physician in the home or office, as well as preventive services. There is no control of the quality of medical service that will be provided, and no plan to set up minimum standards. In essence, Federal and State moneys are to be turned over to existing and future voluntary insurance plans (and in States where Blue Shield operates through commercial insurance companies, to such companies), without control. These moneys, it should be emphasized, are not to be used to pay premiums, but to pay for services through the insurance company. Thus, the bill does not really extend prepaid health insurance at all. The voluntary plans, particularly the Blue Shield, are completely controlled by physicians, even in their nonmedical policy and administrative phases. Consumer representation on the State Hospital and Medical Care Council is inadequate. The cost of the plan, if all who are in need are to be taken care of, will be enormous, and yet this money is to be turned over to the existing and inadequate voluntary health-insurance plans without public control. There is no special provision to provide for improved medical facilities in the rural areas, where voluntary insurance plans are scanty.

We do not wish to enter into a detailed discussion of another unfortunate feature of the bill, namely, the inevitable establishment of a means test to determine from time to time who may be eligible for complete, who for partial, payment of his medical care. Consumer groups have already protested against this reintroduction of the charity concept into the field of public medicine. Determination of eligibility would demand a complex, burdensome, and expensive administrative machinery.

In our opinion bill 1456 would not lead to the improved distribution of better medical care.

S. 1581: This bill provides grants-in-aid to the States for extending medical, dental, and hospital services to individuals unable to pay the whole cost thereof. Thus, it is the indigent and medically indigent who are to be provided for. This means the introduction of the means test, as in S. 1456, with all the disadvantages that have already been cited. The funds to be appropriated, starting at $150,000,000 and rising to $300,000,000 after two years even when matched by State funds will be quite inadequate to meet the present need. To take care of the medical needs of only a fifth of the population, surely a low estimate of those who need assistance in paying for decent medical care, would cost about a billion dollars a year.

Although the bill permits the rendering of services through voluntary insurance plans, this is not mandatory, and actually the bill does not envisage coordinated development or prepayment for medical services, a method which even the American Medical Association now recognizes as essential for the proper distribution of medical care. The bill provides in essence moneys for medical relief. It will not make medical care more readily available to the large number of families (about 50 percent of the population) living on family incomes of $3,000 or less.

It does not encourage the development of group practice, nor attempt to set patterns for the development of methods for the wider distribution of high-quality medical care.

We disapprove of this bill as a whole because it does not provide a true national health program; because it sets patterns of legislation that tend to freeze the worst phases of present-day methods of medical care—charity medicine—which will prevent or retard the development of more adequate methods; because it establishes the means test as a prerequisite for obtaining medical care; because it turns over to the States large Federal funds with little or no control as to how they will be spent; and because it introduces an artificial and costly barrier between methods of disease prevention and of medical care.

S. 1679: This bill sets forth a broad, well-integrated Federal program to promote the national health and to furnish adequate health services to most of the people. We approve of the bill in principle because it provides a comprehensive, realistic national health program. In the short time at our disposal we cannot discuss all aspects of this inclusive measure and shall restrict ourselves largely to comments on the quality of medical care that can be furnished under the provisions of the bill, and to the effect it will have on physicians and on their relationships with their patients.

Prepaid personal health-insurance benefits: We approve of the purposes and principles of this title. We favor the social-security principle of payment in which taxes collected on a broad base are earmarked for health purposes. This assures that sufficient moneys will be available year in, year out for the payment of medical services, and that each worker will make his own payment toward the cost of his own medical care, the payment being apportioned to his ability to pay.

We approve of the wide coverage to include most of the population of the United States; we know of no method of extending coverage gradually. We grant that today the medical facilities and personnel of the country are inadequate to provide complete service under the proposed program. We regard this as evidence of the great medical deficiencies in the United States and believe that the bill will prove the best stimulus for bringing these services up to the required volume and equality. If necessary it would be better to defer the effective date of this title a few more years beyond 1951 to make it possible to fill the needed gaps in hospitals, health centers, and professional personnel, rather than to commence the service with partial coverage, or with grave deficiencies in available services.

The general plan of administration is satisfactory and assures decentralization of administration and gives each State considerable latitude in the details of its administrative plan. At the same time it assures the setting and maintenance of adequate medical standards.

Compulsory health insurance is a prepayment plan that provides comprehensive medical services. Thorough medical care becomes possible because the plan makes available all needed preventive, diagnostic, and curative services by a family physician of the patient's choice, services of specialists when required, hospital care, laboratory and X-ray services, unusually expensive medicines, and special appliances. The patient will be encouraged to seek medical help at the first sign of illness, as well as for preventive services. The physician will find his relationship with his patients unimpeded by economic barriers. The problem of whether or not the patient can afford desirable diagnostic and therapeutic procedures will no longer arise. Preventive and curative medicine will for the first time come into its own on a large scale, as it is carried out today in the voluntary and public hospital.

The mere removal of the financial handicap will lead to better and more thorough medicine for the many who today are unable to pay for good medical care. The establishment of minimum standards for recognition of specialists and hospitals will correct many present abuses. Compulsory health insurance, if combined with group practice—and this bill makes special provisions for the encouragement of group practice—opens up far greater possibilities. If organized groups of physicians contract with the insurance fund to be responsible for the complete care of an appropriate number of patients, the average quality of medical care throughout the country will be greatly improved. Group practice under the insurance plan not only affords the patient the best type of medical care, but gives the doctors the greatest autonomy both in their professional work and in the method of their compensation. The group would draw capitation allowances from the insurance fund, and the partners of the group could then compensate themselves out of these payments in any manner that seemed best to them.

It is often stated that compulsory health insurance will impair the relationship between patient and doctor, and specifically that it will interfere with freedom of choice of physician. The reverse is true. In actuality today, freedom of choice of physicians is denied to a large number of individuals throughout the Nation. For example, 1,000,000 persons attending the out-patient clinics of voluntary and municipal hospitals in New York City in 1948—nearly one-seventh of the population of the entire city—had no freedom of choice of physician. During the same year over 75 percent of all hospital beds in New York were located on the wards, admission to which is usually by rotation, where patients are cared for by physicians usually completely unknown to them. For many of these individuals the establishment of compulsory health insurance, far from interfering with freedom of choice, will create it for the first time, just as it will represent to many people their first opportunity to experience the very doctor-patient relationship under discussion.

The bill makes every attempt to safeguard the professional integrity and individuality of the physician. Physicians have the right to establish their practices in the locality of their own choosing, subject to the State licensing laws. They have the right to reject individual patients. Maximum limits upon the number of eligible individuals with respect to whom any one physician may undertake to render service in any local health service area can be set only on recommendation of the professional committee in that area that such limitation is necessary to maintain high standards in the quality of services furnished as benefits. Such a provision is nothing more than a recognition of the self-evident fact that a physician cannot handle more than a given number of patients without imposing excessive physical and mental strain on himself and thereby impairing the quality of his work. Such self-imposed limitations of the number of patients cared for by a single doctor exist today, and will continue to exist under any system of medical care.

In setting payments for professional workers, the bill states that regard shall be had for the annual income which the payments will provide, and consideration shall be given to degree of specification, skill, experience, and responsibility involved in rendering services. Further, that such payments shall be adequate to provide professional and financial incentives to practitioners to advance in their professions, to encourage high standards in the quality of services rendered, to give assistance in their use of opportunities for postgraduate study, and to allow for adequate vacations.

These principles will assure to the physician his traditional autonomy, and will give him a much greater degree of financial security than he has today. Indeed, because physicians will be paid for caring for many patients whom they now treat gratuitously, their average income will be increased. It is only the high-priced specialist, whose charges today often appear out of proportion to the services rendered, and to the capacity of the patient to pay, who may suffer some impairment of income. In setting standards for the compensation of doctors, due consideration should be given to the present median income of competent successful physicans, and payments should be so adjusted as to maintain present standards of average income.

Since our view that national health insurance would offer many advantages both to the public and to the physician is contested by some, it seems appropriate at this point to discuss some of these objections and objectors.

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(*b*) However, many physicians today oppose compulsory health insurance, it is reasonable to believe that many more would endorse it were they afforded a fair opportunity through the medical press to be honestly and impartially informed of the real facts on the matter. Today, unfortunately, there is no such opportunity. The medical press is a controlled press offering remarkably uniform editorial comment throughout the Nation. Some publications use as editorials materials furnished from a central source.

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It is asserted, for example, that compulsory health insurance is "un-American," "alien," "foreign," "imported," and so on. Leaving aside the fact that this is a falsehood—witness the national compulsory school and income taxes, and compulsory automobile insurance in several States—it is of more than passing interest to a psychiatrist to hear such argument from American physicians who are traditionally international in their scientific orientation. No worthy American doctor would brand penicillin as English, the Wassermann reaction as German, or pasteurization as French. These and many other medical advances have been judged and accepted or rejected on the basis of merit.

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The issue of health in this Nation cannot be approached in an atmosphere of panic and hysteria. Attempts to frighten the American public by cries of "communism" and "socialism" will fail. A fair and objective presentation of the nature of the proposal to establish compulsory health insurance, replacing the blindness of fear by the cold light of reason, will serve to persuade many of our citizens and our colleagues of the great service which this measure may bestow upon all of the American people.

(The statement submitted by Dr. Meyer is as follows:)

Statement of Dr. Bernard Meyer, Physicians Forum

I speak for the Physicians Forum, a national organization of physicians, all of whom are members either of the American Medical Association or of the National Medical Association, interested in studying methods for the improvement and wider distribution of medical care, and in furthering the development of new techniques that will help to achieve this end. At a membership meeting held on June 12, 1947, the national compulsory health insurance principle as embodied in Senate bill 1320 was approved. At a meeting of the executive committee of the Physicians Forum held on May 31, 1949, Senate bill 1679 was approved in principle, and the conclusion was reached that Senate bills 1581 and 1456 would not provide basic improvement in the quality of medical care and that they set bad patterns of administration. It was voted to authorize a representative to appear before this committee in the name of the forum in support of S. 1679 and in disapproval of S. 1581 and S. 1456.

It is no longer necessary to point out the health problems of the Nation, nor to enumerate the many unmet medical needs of a large proportion of our population. The proponents of these bills, well aware of these defects in the medical structure in this country, have each in his own way attempted to provide a mechanism for correcting these inequalities of medical care. The problem to which we must address ourselves is how successfully will each one of these bills correct existing inadequacies of medical care? As physicians we are aware of the great need for ready access to full medical facilities for those who cannot afford to buy medical care; but we are equally concerned to make sure that any measures that may be instituted will assure that this medical care be of the best; not alone that the quality of care should not deteriorate, but that it should be improved. We wish to discuss these several bills primarily from this point of view.

All of the bills except S. 1581, recognize the fact that today the adequate distribution of medical care must be channeled through a prepayment system. Senate bill 1456 would do this by means of subsidies to existing and future voluntary medical care insurance systems. It is necessary therefore first to inquire into the structure and methods of existing voluntary health insurance plans. The following remarks apply to most of the present voluntary plans, in particular the Blue Shield plans.

With few exceptions they do not offer comprehensive coverage of medical needs, the benefits are restricted to hospitalization and the cost of operations, and certain professional expenses when the patient is in a hospital. Moreover the income limits set for subscribers entitled to service benefits are so low that voluntary medical care insurance actually becomes a cash indemnity plan, offering only partial protection. The cost of most illnesses is not included, and there is no provision for preventive services, and no encouragement for the patient to visit the doctor at the first sign of illness. Thus, these plans do not offer any fundamental solution to the problem of providing good medical care.

The voluntary insurance plans that operate with large panels of physicians compensated by the fee-for-service method have no control of the quality of medical service offered to their clients. In this, they resemble the commercial health insurance plans which have nothing to offer but an indemnification for some of the costs of illnesses. It is strange that the very voluntary health insurance plans that neglect to assure high quality medical service are those set up and operated by physicians with little or no representation in management of the public which buys the services. In many States the medical societies have succeeded in having laws passed that give them a monopoly in setting up health insurance plans, and which prevent cooperatives and other community groups, such as the one sponsoring the health insurance plan of New York, from establishing their own health plans.

The set-up of most voluntary health insurance plans sharpens the cleavage between preventive and curative medicine at a time when the changing face of disease, induced by the efficient control of the infectious diseases, has brought about a reorientation of public health activities. The so-called chronic degenerative diseases today are the major health problem, and none of the conventional methods of preventive medicine will ward off any of these disorders. Public health officers have recognized that the most potent weapon for their control is immediate and ready accessibility to physicians and medical facilities both for diagnosis and treatment.

S. 1456

Bill S. 1456 proposes to provide hospital and medical care to those unable to pay all or part of the costs by giving them service cards which will entitle them to services from a voluntary health-insurance plan. Grants-in-aid are made to the States, and these set up State agencies which administer the plan. The provision for medical care is very incomplete: it omits the services of the physician in the home or office, as well as preventive services. There is no control of the quality of medical service that will be provided, and no plan to set up minimum standards. In essence Federal and State moneys are turned over to existing and future voluntary insurance plans, and in States where Blue Shield operates through insurance companies, to such commercial insurance companies, without control. These voluntary insurance plans, particularly the Blue Shield plans, are completely controlled by physicians, even in their nonmedical policy and administrative phases. Furthermore, the State hospital and medical care council is so set up that the majority consists of physicians, hospital administrators, and health insurance administrators. The public, the consumers of medical care, are in the minority. The cost of the plan, if all who are in need are to be taken care of, is large and will surely exceed $1,000,000,000. Yet this money is to be turned over to the existing inadequate voluntary insurance plans without public control, without any certainty that the funds will be expended in the best manner to serve the persons who are supposed to benefit. There is no special provision to provide for improved medical facilities in the rural areas.

We do not wish to enter into a detailed discussion of another unfortunate provision of the bill, namely the establishment of a means test to determine from time to time who may be eligible for complete, who for partial, payment of his medical care. Consumer groups have already protested against this reintroduction of the charity concept into the field of public medicine. Determination of eligibility would demand a complex, burdensome, and expensive administrative machinery.

In our opinion the bill S. 1456 would not lead to the improved distribution of better medical care. It would set up administrative precedents that are open to great abuse, and that would set back the development of adequate medical-care plans and serve as a bar to future progress in the field.

S. 1581

We wish first to discuss the medical-care features of this bill. It provides grants-in-aid to the States for extending medical, hospital, and dental services to individuals unable to pay the whole cost thereof. Thus it is the indigent and medically indigent who are to be provided for. This means the introduction of the means test, as in S. 1456, with all of the disadvantages that have already been cited. The institution of the charity concept as the basis for eligibility for benefits reverses the trend that is finding ever greater general acceptance, namely that health and medical measures are services that should be available to all citizens regardless of financial need. The funds to be appropriated, starting at $150,000,000 and rising to $300,000,000 after 2 years, even when matched by State funds will be quite inadequate to meet the present need. To take care of the medical needs of only a fifth of the population, surely a low estimate of those who need assistance in paying for decent medical care, would cost about a billion dollars a year.

The bill provides that medical services may be provided in institutions, in the home, or in physicians' or dentists' offices, and that services may be furnished by means of payments to voluntary nonprofit health-insurance plans. Not more than 25 percent of the expenditures of the States under the plan may be used for dental services, the development of voluntary nonprofit insurance plans, the establishment and improvement of diagnostic facilities, and the creation of inducements for physicians and dentists to practice in areas which without such inducements would be unable to attract needed practitioners.

To be eligible for Federal aid each State must submit a plan for carrying out its purposes. It must designate the State health agency as the sole administrative agency, provide satisfactory methods of administration including personnel standards on a merit basis, establish an advisory council appointed by the governor. It must be so planned that within 5 years medical and hospital services without discrimination will be provided to all those families and individuals in the State unable to pay the whole cost thereof, and to provide dental services as far as practicable to such persons. Standards for the services to be provided must be set. Plans that meet the requirements set forth in the bill must be approved by the Director and no plan may be disapproved because the Director disapproves of the methods proposed provided that the program is designed and calculated to achieve by July 1, 1954, the required objectives set forth in the bill at a cost within the probable financial resources of the State with Federal aid.

Although the bill permits the rendering of services through voluntary insurance plans, this is not mandatory, and actually the bill does not envisage a coordinated development of prepayment for medical services—a method which even the American Medical Association now recognizes as essential for the proper distribution of medical care. The bill provides in essence moneys for medical relief, and will tend to freeze the present methods of "charity medicine." It will not make medical care more readily available to the large number of families (about 50 percent of the population) living on family incomes of $3,000 or less. It does not encourage the development of group practice nor attempt to set patterns for the development of methods for the wider distribution of high quality medical care.

Under the over-all plan for establishing a National Health Agency under which will be consolidated all of the health functions of the Federal Government it is proposed to set up the Public Health Service and the Office of Medical, Dental and Hospital Services as separate bureaus, each under its own director. Thus, the administration of preventive and curative medicine would be separated. This runs counter to the theories and practices of the leaders in the public health field today. Both at the Federal and State levels the Medical and Dental Care Councils, which are advisory bodies, have memberships two-thirds of which represent professionals in the fields pertaining to medical, hospital and dental care, and only one-third the consumer; that is, the general public. Consultation of the Federal Council by the Director is optional; he is not required to consult the council even on matters of important policy. Such councils should consist primarily of the consumers of medical care, who pay for it and who should have the opportunity of controlling the amount and kind of medical care that they wish to have, as well as the methods of distribution. Advisory committees of professionals are most useful, and find their proper function in the consideration of technical aspects of the actual operation of the program.

Most of the health services of the Government have recently been consolidated under the Federal Security Administration. The proposed reshuffling of these agencies under a National Health Agency appears to be unnecessary and merely adds to administrative complexities. The provision that the National Health Administrator be a physician appears unnecessary, if not unsound in view of the varied activities, including welfare, which will be under the administration of the new agency. Moreover it is accepted public policy that the over-all administrator even of a professional agency (e. g. the Secretary of Defense or of Labor) be a representative of the public, rather than of the professional groups under his direction.

Title III, to provide health services for school children, provides insufficient funds to carry out an adequate program of prevention and treatment of physical and mental defects in school children. It does not set and safeguard high standards of medical care. In a complete and satisfactory national health program these needs of the school population could be met without setting up a separate category of benefits.

Titles IV, V, and VI are common to other bills that have been presented and we approve their general purposes and methods. It is to be hoped that the proponents of these several measures will cooperate to separate these titles from the bills providing medical-care programs and proceed to their early enactment.

We disapprove of S. 1581 as a whole because it does not provide a true national health program; because it sets patterns of legislation that tend to freeze the worse phases of present-day methods of medical care, and that will prevent or retard the development of more adequate methods; because it establishes the means test as a prerequisite for obtaining medical care; because it turns over to the States large Federal funds with little or no control as to how they will be spent; and because it introduces an artificial and costly barrier between methods of disease prevention and of medical care.

S. 1679

Senate bill 1679 sets forth a broad, well-integrated Federal program to promote the national health and to furnish adequate health services to the people. We approve of the bill in principle because it provides a comprehensive, realistic national health program. In the short time at our disposal we cannot discuss all aspects of this inclusive measure, and shall restrict ourselves largely to comments on the quality of medical care that can be furnished under the provisions of the bill, and to the effect it will have on physicians and on their relationships with their patients.

Title 1—Education of health personnel.—The cost of medical education has risen so that the medical schools of the country are facing bankruptcy. Without liberal subsidy they cannot continue. Yet the country's need is for more and for still better trained physicians. Therefore the plans to support medical schools and to offer them financial inducements to increase the number of students enrolled is desirable, provided the quality of teaching is maintained. Scholarships to enable students whose parents are not wealthy to prepare for the professions are sorely needed. It seems fair to require students who have benefited from such scholarships to give some service to their country in return for the opportunities given them. But care must be taken that this service is not made too onerous, and does not interrupt their further medical education.

We are not qualified to discuss the other professions enumerated in the bill, but the same principles would seem to apply to them as to the medical profession.

Title II—Aid to medical reesarch.—There is no difference of opinion in regard to the need for additional funds for medical research. It seems unwise to designate special diseases as subjects of investigation through the establishment of special institutes under the United States Public Health Service. Such a categorical approach to research problems does not lead to the best results and may involve much waste of funds.

Title III—Liberalization of the Hospital Survey and Construction Act.—The present hospital and construction act has proved its worth. This bill doubles the annual appropriation and enables the poorer States to obtain up to two-thirds subsidy for hospital construction. It gives special encouragement to the construction of facilities for group practice, and broadens the definition of the term "hospital" to include public health centers and other facilities for the institutional care of the sick. The bill further authorizes research projects on the further development and coordination of hospital services and facilities.

Title IV—Special aid for rural and other shortage areas.—The provision of special grants and loans to enable doctors and other professional workers to settle in rural areas, to supplement local funds for the construction and maintenance of hospitals, and for the establishment of group practice units offers a practical and satisfactory method of developing needed medical services in rural areas. Further aid is projected in the provision for assistance to farmers' experimental health cooperatives.

Title V—Grants to States for public health work.—This extends and liberalizes the existing system of grants-in-aid and gives special recognition to the need of developing a preventive medicine program in the field of the chronic diseases which today are the chief causes of illness and death.

Title VI—Research in child life, and grants for maternal and child health and crippled children's services.—The proposal to foster research in child life and development appears admirable in itself but does not seem directly pertinent to a bill designed to set up a national health program. In part B it is proposed to expand and improve the services and facilities of the maternal and child health program and the program for crippled children. The work of the Children's Bureau in these fields has been admirable, and in the absence of a national health program has filled a real need. But in a bill that plans to set up a broad program for medical care for most of the population, such a categorical approach to preventive and curative medicine seems undesirable. The establishment of arbitrary ages, such as 18 and 21 to delimit childhood for the purpose of this section will lead to confusion and overlapping. If the provisions for prepaid personal health insurance benefits become law, this young group of the population will be taken care of, and the valuable work of the Children's Bureau should then be coordinated with the general program.

Title VII—Prepaid personal health insurance benefits.—This section is substantially the same as S. 1320 (1947) so that we can but reiterate our comments thereon made before the Senate committee on June 25, 1947. We approve of the purposes and principles of this title. We favor the social-security principle of payment in which taxes collected on a broad base are earmarked for health purposes. This assures that sufficient moneys will be available year in, year out for the payment of medical services, and that each worker will make his own payment toward the cost of his own medical care, the payment being apportioned to his ability to pay.

We approve of the wide coverage to include most of the population of the United States: we know of no method of extending coverage gradually. We grant that today the medical facilities and personnel of the country are inadequate to provide complete service under the proposed program. We regard this as evidence of the great medical deficiencies in the United States and believe that the bill will prove the best stimulus for bringing these services up to the required volume and quality. If necessary it would be better to defer the effective date of this title a few more years beyond 1951 to make it possible to fill the needed gaps in hospitals, health centers, and professional personnel, rather than to commence the service with partial coverage, or with grave deficiencies in available services.

The general plan of administration is satisfactory and assures decentralization of administration and gives each State considerable latitude in the details of its administrative plan. At the same time it assures the setting and maintenance of adequate medical standards. We believe that the principal authority at the national level should be vested in the Surgeon General of the United States Public Health Service rather than a five man board. Experience has shown, and the Congress has in the past acted on such experience (e. g., the Social Security Board, and the Surplus Property Board) that board administration is unwieldy and ineffective, and such boards have been replaced by individual administrators. The establishment of authoritative advisory boards at all levels, and the required reports to the Congress should act as adequate safeguards against arbitrary action by the administrator. The same reasons speak against the advisability of establishing committees as local administrative units.

Compulsory health insurance is a prepayment plan that provides comprehensive medical services. Thorough medical care becomes possible because the plan makes available all needed preventive, diagnostic, and curative services by a family physician of the patient's choice, services of specialists when required, hospital care, laboratory and X-ray services, unusually expensive medicines and special appliances. The patient will be encouraged to seek medical help at the first sign of illness, as well as for preventive services. The physician will find his relationship with his patients unimpeded by economic barriers. The problem of whether or not the patient can afford desirable diagnostic and therapeutic procedures will no longer arise. Preventive and curative medicine will for the first time come into its own on a large scale, as it is carried out today in the voluntary and public hospital.

The mere removal of the financial handicap will lead to better and more thorough medicine for the many who today are unable to pay for good medical care. The establishment of minimum standards for recognition of specialists and hospitals will correct many present abuses. Compulsory health insurance, if combined with group practice—and this bill makes special provisions for the encouragement of group practice—opens up far greater possibilities. If organized groups of physicians contract with the insurance fund to be responsible for the complete care of an appropriate number of patients, the average quality of medical care throughout the country will be greatly improved. Group practice under the insurance plan not only affords the patient the best type of medical care, but gives the doctors the greatest autonomy both in their professional work and in the method of their compensation. The group would draw capitation allowances from the insurance fund, and the partners of the group could then compensate themselves out of these payments in any manner that seemed best to them.

We disapprove of the fee-for-service method of payment as the chief method of compensating physicians, either individually or in groups, because experience has shown that it creates a great amount of paper work for doctors and the administration, and that it inevitably leads to abuse by doctor and patient.

It is often stated that compulsory health insurance will impair the relationship between patient and doctor, and specifically that it will interfere with freedom of choice of physican. The reverse is true. In actuality today freedom of choice of the physician is denied to a large number of individuals throughout the Nation. For example, the one million persons attending out-patient clinics of voluntary and municipal hospitals in New York City in 1948—nearly one seventh of the population of the entire city—had no freedom of choice of physician. During the same year over 75 percent of all hospital beds in New York were located in the wards, admission to which is usually by rotation, where patients are cared for by physicians usually completely unknown to them. For many of these individuals the establishment of compulsory health insurance, far from interfering with freedom of choice, will create it for the first time, just as it will represent to many people their first opportunity to experience the very doctor-patient relationship under discussion.

The bill makes every attempt to safeguard the professional integrity and individuality of the physician. Physicians have the right to establish their practices in the locality of their own choosing, subject to the State licensing laws. They have the right to reject individual patients. Maximum limits upon the number of eligible individuals with respect to whom any one physician may undertake to render service in any local health service area can be set only on recommendation of the professional committee in that area that such limitation is necessary to maintain high standards in the quality of services furnished as benefits. Such a provision is nothing more than recognition of the self-evident fact that a physician cannot handle more than a given number of patients without imposing excessive physical and mental strain on himself and thereby impairing the quality of his work. Such self-imposed limitations of the number of patients cared for by a single doctor exist today, and will continue to exist under any system of medical care.

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Senator DONNELL. I would like to ask the Doctor some questions.

Dr. Meyer, are you a psychiatrist?

Dr. MEYER. I am, sir.

Senator DONNELL. Would you tell us, please, something of your own professional background, where you received your preliminary education, medical education, and subsequent experience?

Dr. MEYER. I am a graduate of Harvard College.

Senator DONNELL. When did you graduate?

Dr. MEYER. In 1932.

Senator DONNELL. 1932?

Dr. MEYER. Bachelor of Arts.

Senator DONNELL. Bachelor of Arts at Harvard, in 1932?

Dr. MEYER. Yes, sir.

Senator DONNELL. And, next?

Dr. MEYER. I got my medical degree from Cornell University Medical College in 1936.

Senator DONNELL. What degree was that, Doctor of Medicine?

Dr. MEYER. M. D.

Senator DONNELL. Have you received any other degrees?

Dr. MEYER. I have had no other degrees.

Senator DONNELL. Have you had any experience, any studies, first-hand of the experience of Great Britain in the matter of compulsory health insurance?

Dr. MEYER. I have never been to England, if that is what you mean, Senator.

Senator DONNELL. I wondered if you had studied their history and experience.

Dr. MEYER. I believe I have a general familiarity with it.

Senator DONNELL. I want to ask you a few questions along that line, in a few minutes.

Where is your home, Doctor? New York City?

Dr. MEYER. New York City.

Senator DONNELL. Are you a native of New York City?

Dr. MEYER. I am a native of New York State.

Senator DONNELL. How long have you lived in New York City?

Dr. MEYER. I have lived in New York City since 1932.

Senator DONNELL. How long have you been connected with the Physicians Forum?

Dr. MEYER. About 3 years, I would say.

Senator DONNELL. Are you an officer of that organization?

Dr. MEYER. I am, I am chairman of the New York County chapter and treasurer of Physicians Forum.

Senator DONNELL. Is Dr. Earnest P. Boas still head of the Forum?

Dr. MEYER. He is chairman.

Senator DONNELL. Doctor, would you tell us, please, what is the present membership of Physicians Forum?

Dr. MEYER. I couldn't tell you precisely, Senator. I should judge about 1,600.

Senator DONNELL. It has had considerable growth in the last 2 or 3 years; is that right?

Dr. MEYER. I think we have added some to our membership.

Senator DONNELL. In testifying on June 25, 1947, Dr. Boas testified on page 619 of the record, that the Physicians Forum had been in existence for 7 years—yes, that is on page 618—where he says:

> Physicians Forum has approximaely a thousand members.

Are you quite sure there has been that much growth in the last 2 years?

Dr. MEYER. I would say roughly we probably gained about 500 members.

Senator DONNELL. Where is your membership located, in the greatest part?

Dr. MEYER. The greatest part, I should say is in New York City. We also have a chapter in Boston; there is a chapter in Chicago; and, I believe we have a chapter in Washington.

Senator DONNELL. Do you have any members west of the Mississippi River?

Dr. MEYER. Yes; we have.

Senator DONNELL. Approximately how many?

Dr. MEYER. I wouldn't know.

Senator DONNELL. Would you know whether you have as many as 500?

Dr. MEYER. I couldn't say, Senator.

Senator DONNELL. You think your membership is about 1,500. Is that your estimate, or sixteen or seventeen hundred—which would you say, so that we can get at some figure, if you know?

Dr. MEYER. I don't know precisely. I would say somewhere between 1,500 and 1,600.

Senator DONNELL. What proportion of those are in New York City?

Dr. MEYER. I really don't have the figures at my disposal, Senator. I should imagine something like a third.

Senator DONNELL. About a third.

Senator MURRAY. Could you prepare a statement for us and give the membership, and distribute the membership of the organization, so we will have it in the record?

Dr. MEYER. I will be glad to, Senator.

Senator DONNELL. Let me ask you, on page 619 of the testimony in 1947, Dr. Boas was asked this question and made this answer:

> Now, as a matter of fact fully two-thirds of your membership are in a radius of not to exceed 250 miles from the Atlantic Ocean; that is correct, is it not?
>
> Dr. BOAS. Probably; yes.
>
> Senator DONNELL. That is your best judgment?
>
> Dr. BOAS. Yes.

Is that your judgment today, Doctor?

Dr. MEYER. I would certainly defer to that opinion. I think that is correct.

Senator Donnell. Now, Doctor, in the course of your statement, and I may say I missed the early part of it and I was not able to follow, with the rapidity with which you were reading your summary, all of which you read and I am trying to follow it in this more complete statement; but, I did notice when you got down to S. 1581, in the course of your statement on that you said:

> We disapprove of S. 1581 as a whole because it does not provide a true national health program.

You mean to say there is nothing in that bill that you approve?

Dr. Meyer. Excuse me a moment.

Senator Murray. In your complete statement, you discussed 1581 in some degree, starting in the middle of page 2.

Senator Donnell. Down at the bottom of page 3, let me ask you if you recall—by the way, did you prepare the statement yourself, Doctor?

Dr. Meyer. Largely, sir.

Senator Donnell. Did you prepare the part which says:

> We disapprove of S. 1581 as a whole because it does not provide a true national health program—

and so forth.

Dr. Meyer. Yes, sir; I think there may be some confusion of meaning. That does not mean in its entirety.

Senator Donnell. What does it mean?

Senator Murray. As a whole?

Dr. Meyer. As a whole.

Senator Donnell. Do you disapprove of the whole, don't approve of some parts, or do you approve of some parts? Which do you mean?

Dr. Meyer. Senator, it is my understanding that the phrase "as a whole" means in its entirety. The general impression, or the general feeling, about the bill is, as a unit, it is one of disapproval although it might contain and does contain titles or aspects to which we give our endorsement.

Senator Donnell. Could you tell us what particular portions of that bill it is that you do approve?

Dr. Meyer. Well, there are aspects of this bill which I think of as objectives, those to which many of us subscribe, such as the extension of the Public Health Service and the aid to medical schools, and so forth.

Senator Donnell. Well, you say that you disapprove of it because it does not provide a true national health program, and then you say—

> because it sets patterns of legislation that tend to freeze the worst phases of present-day methods of medical care.

What do you mean by that and what are those phases that S. 1581 tend to freeze?

Dr. Meyer. This refers particularly to persistence of a division of those individuals who can and cannot pay for medical services, and particularly the involvement of the charity principles.

Senator Donnell. What are you talking about when you say "present-day methods of medical care," and you assert that this S. 1581 "sets patterns of legislation that tend to freeze the worst phases of present-day methods of medical care?" You are not talking there about the matter of means test, are you?

Dr. MEYER. No. The means test is embodied in the bill as a means of determining——

Senator DONNELL. You say here that this bill, S. 1581—

> sets patterns of legislation that tend to freeze the worst phases of present-day methods of medical care.

What are those "worst phases of present-day methods of medical care" that are tended to be frozen by S. 1581?

Dr. MEYER. I would say the division of the population into indigent or medically indigent who have to be aided through the charity principle, and those individuals who are able to take care of their own medical bills through their own payment.

Senator DONNELL. Is that what you are talking about when you refer to medical care? I thought when you said, "methods of medical care," you were talking about the method of treating disease.

Dr. MEYER. No; that doesn't refer to the treatment of disease.

Senator DONNELL. So you are talking about, then, when you say "the worst phases of present-day methods of medical care"—you are not indicating that S. 1581 tends to perpetuate or freeze improper methods of treatment of disease. You don't mean anything of that kind; is that right?

Dr. MEYER. That is correct, but I would like to emphasize that the meaning is a little bit beyond simply the question of distribution, and that is that this bill, similar to the other, S. 1456, is not oriented around the principles of preventive medicine, periodic check-ups, inoculations and so on, but is, on the contrary, geared to enabling individuals to pay for medical care when they need it, by becoming ill.

Senator DONNELL. Doctor, your statement here, at least to me, is very confusing.

You say now, in your oral statement, that when you referred to "methods of medical care," and what I have quoted you, you are not talking about methods of treatment; yet, you proceed right after using that expression in your statement, with this language:

> and that will prevent or retard the development of more adequate methods.

Are you not talking about methods of medical care, or medical treatment?

Dr. MEYER. No; I am referring to the whole orientation toward the problem of sickness. This does not refer to the administration of drugs or the proper indication of operations, or other therapeutic procedures; but, as an orientation to the whole problem of illness.

Senator DONNELL. Doctor, I don't know what you mean by "orientation."

I would like to have you explain that to me so that I can understand, when you say "methods of medical care" tend to be frozen—when you say they are not methods of medical care as the ordinary person understands that, which would be the way in which patients are taken care of medically—isn't that what that language means in the ordinary acceptance?

Dr. MEYER. No; I don't think such a narrow meaning is implied here, Senator.

Senator DONNELL. Well, were you not, when you prepared this portion of this statement, using some very general drastic, broad language here of criticism of S. 1581, on the grounds that it was first going to freeze the worst phases of present-day methods of medical care, and that you meant to imply that S. 1581 is going to tend to perpetuate or freeze certain poorly devised means of taking care of patients, and that you indeed follow that up with something that indicates that is your meaning by saying:

> and that will prevent or retard the development of more adequate methods.

Am I not correctly analyzing the meaning there that the ordinary reader would infer or get from what you have written here, along that line?

Dr. MEYER. Senator, I don't think so; but, I cannot instruct the reader, obviously, to interpret things according to my own meaning.

Senator DONNELL. You are a psychiatrist. You understand how people generally react to language.

Dr. MEYER. Quite true.

Senator DONNELL. The language I read, when you talk about medical care, and more adequate methods, the average man on the street would understand that you are criticizing S. 1581 on the grounds that it is going to perpetuate poor methods of caring for patients.

Now, isn't that what the average man would understand, in reading what you have written there?

Dr. MEYER. Well, I hope not; but, if you say so, I daresay that it might be.

I do think that your meaning, as you see it, would have been conveyed had the sentence read as follows:

"It sets patterns of legislation that tend to freeze the worst phases of present-day medical care," when the words "method of" are left out. I don't believe that this refers or should refer in your own mind to techniques of the administration of drugs, or the actual operational aspects as it affects the patient.

Senator MURRAY. Right there I would like to make an observation. I think I am a reasonable man, and I inferred from his language there, that he had reference to some of the practices that prevail in the country such as, for instance, kick-backs and splitting fees. We have indicated a great many doctors in the United States a short time ago for indulging in the practices of that kind, haven't we; and, there are many other things that could be frozen into the practice that exists today, if we permitted it to be frozen there.

Senator DONNELL. Let me ask you, Doctor: Do you consider a kickback as a method of medical care? Is that what you are talking about? Would you use the expression "methods of medical care"?

Dr. MEYER. I don't think that this is obviously a method of medical care. I think it is a byproduct, an unfortunate byproduct that obtains in a certain aspect of our medical science, and one which might very well be perpetuated under a program of this sort.

Senator DONNELL. Doctor, I will not debate the question with you. I will just say, however, that regardless of whatever you may have intended, I certainly would understand, when I read the language—

> to freeze the worst phases of present-day methods of medical care, and that will prevent or retard the development of more adequate methods—

I would understand you are talking about the methods of what the ordinary man on the street understands to be medical care, the care a doctor gives to a patient, and that you are indicating and indicting S. 1581 on the grounds that it would freeze the worst phases of present-day methods of such treatment or care and retard and would prevent the development of more adequate methods.

If you didn't mean that, all well and good.

Now, you say, Doctor, that you disapprove of S. 1581—

> because it turns over to the States large Federal funds with little or no control as to how they will be spent.

Have you read S. 1581?

Dr. MEYER. I have, sir.

Senator DONNELL. Did you read part of it that pertains to the requirement that States shall submit plans and the provision for the operation of States plans, and the provision that no certification will be made under the section 213, in event that it is found that the State and its governmental subdivisons have failed to provide toward the carrying out of such plan at least as much as the sums required to be provided, and so on and so forth.

Have you read all of those sections?

Dr. MEYER. Yes; I have.

Senator DONNELL. You think that S. 1581 is pretty clear in setting forth what has to be in a State plan, and contains checks designed to prevent the use of Federal funds if the State goes back on the plan; don't you agree to that?

Dr. MEYER. I think, up to that point, that is so; but, from what happens from there on, it isn't so clear to me there will be adequate checks.

Senator DONNELL. What happens thereafter which isn't clear to you?

Dr. MEYER. I understand what you have just stated, namely, that the plan has to be submitted and approved; but, after the plan has been approved, then what?

Senator DONNELL. Doctor, if you have read the bill with care, I think you will find the answer to your question. The fact is that there are provisions here with regard to the operation of the State plan, and penalties in the event the State fails to carry out the plan; and, even a provision in the event the director shall provide that no further funds are to go to the State, the State is given authority to appeal to a court. Isn't there certainly adequate provision in this bill to insure, on the one hand, that the Federal Government has some check on the use of its funds; and, on the other hand, that the State has adequate protection in court and through the administrative agencies, as well as in the event the Federal Government shall be unfair in its treatment of the State? Don't you agree with that?

Dr. MEYER. On the upper level of which you speak, yes; but, on the level of the actual administration of medical care by a given physician, I am not aware of provisions in the bill to maintain any particular standards of medical excellence.

Senator DONNELL. Do you think that the administration bill (S. 1679) does contain provisions by which, down on this lower level where the individual physicians are operating, the Federal Government is going to see to it that proper performance is had from those physicians and proper treatment given by the physicians? Is that your interpretation of the administration bill?

Dr. MEYER. The bill of which you speak——

Senator DONNELL. S. 1679.

Dr. MEYER. Does provide for certification of specialists according to those standards which doctors themselves have set up; and, as such, is a protection to the public.

Moreover, under S. 1679, the element of free choice of physicians by the patient would, in itself, encourage the success of those doctors who measure up to the best standards of medical practice.

Senator DONNELL. Doctor, it is a fact—is it not?—as you have indicated in your testimony, that under S. 1679 the Federal Government does retain a very close direct control over the physicians, and over their operations, their performance of their duties, and that that one of the things you are criticizing S. 1581 for is that it does not contain such supervision by the Federal Government. Am I not correct in my analysis of your statement?

Dr. MEYER. I don't believe you are, sir; because 1679, the certification of standards of specialists, for example, is no more under the—if I gather your meaning correctly—no more under the immediate control of the Federal Government than the establishment of standards, say, for individuals who are licensed to practice under workmen's compensation laws as specialists.

Some kind of standards are necessary. The medical societies themselves realize that. The physicians have disciplined themselves to insure that specialists will have certain qualifications. All that the bill S. 1679 states is that those standards should be perpetuated under any Federal health insurance.

Senator DONNELL. You are familiar with the fact that under S. 1679, the administration bill, there is established a National Health Insurance Board? You are familiar with that?

Dr. MEYER. Yes, sir.

Senator DONNELL. Also, at the bottom of page 137, it is provided that—

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator. The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsitent with this title as may be necessary.

You know that; don't you?

Dr. MEYER. Yes, sir.

Senator DONNELL. You know who the present Federal Security Administrator is, too; do you not?

Dr. MEYER. Yes, sir.

Senator DONNELL. Do you know if he is a doctor?

Dr. MEYER. He is not a physician.

Senator DONNELL. Has there ever been a requirement of law that the Federal Security Administrator should be a doctor?

Dr. MEYER. Not to my knowledge.

Senator DONNELL. You would not advocate that there be any such requirement; would you?

Dr. MEYER. No, sir.

Senator DONNELL. Now, the Board is created, and it is provided, is it not, on page 138, after providing that its functions are to be administered under the direction and supervision of this one man who is a Federal official, and he is in Washington; is he not?

Dr. MEYER. Correct.

Senator DONNELL. The bill then proceeds to say that—

> The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title and such other regulations not inconsistent with this title as may be necessary.

You are familiar with that provision?

Dr. MEYER. Yes, sir.

Senator DONNELL. I want to place myself on record as thinking that the point you are making with respect to S. 1581 might very well be applied in the converse to S. 1679; namely, that S. 1679 obviously directs that the Board that I have referred to, this National Health Board, make the regulations, make the standards, not merely those that the title authorizes, but all those that are not inconsistent with the title and that through the action of that Federal Board, here in Washington, directing all over the United States, setting up these regulations and standards—it is in turn under the direction and supervision of one man: the Federal Security Administrator.

Dr. MEYER. Senator, may I call your attention to section 711?

Senator DONNELL. Yes.

Dr. MEYER (reading):

> The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and experience required to qualify an individual to render each such class of specialist services as benefits under this title * * *. In establishing such standards and in determining whether individuals qualify thereunder, standards and certifications developed by professional agencies shall be utilized as far as is consistent with the purposes of this title, and regard shall be had for the varying needs and the available resources and professional personnel of the State and of local health-service areas.

It is quite true that the section which I have just read does establish the Board——

Senator DONNELL. No; that isn't the section establishing the Board. Section 751 does that.

Dr. MEYER. No; the one I am reading.

Senator DONNELL. No; it does not. Section 711, the one you are reading, provides certain duties. You said it was established by that. It is not. It is established by 751, on page 136.

Dr. MEYER. I hadn't finished my reading.

Senator DONNELL. Proceed.

Dr. MEYER (reading):

> The Board, after consultation with the Advisory Council, shall establish standards as to the special skills and experience required to qualify an individual to render each such class of specialist service—

and so forth.

Now, it seems to me that, simply for the sake of administrative efficiency, it is necessary to establish some kind of over-all administrative class here; but, it seems to me also that the participation of physicians, their own experience, the experience of medical societies is to be utilized completely in establishing these qualifications, and I see no reason to utilize the section which you read, as an indication that

Mr. Ewing, for instance, out of his own experience, is going to decide what are the proper qualifications for psychiatrists, or how much training a neurologist should have before he becomes a neurologist; or whether an ophthalmologist is going to be qualified on the basis of having tested some eyeglasses, and so on.

Senator DONNELL. Dr. Meyer, the section that you have read from is section 711. In the first place, I want to call attention to the fact that it is referring to a very limited class of functions; namely, the standards as to the special skills and experience required to qualify an individual to render specialist services. This is a very narrow portion of the bill. Seven hundred and eleven is important and contains the language that you very correctly read; but, let me call your attention to the fact that in the first place the Board that is referred to therein is the Federal Board, and, while it is directed that these standards and so forth be obtained from local varying needs in the various parts of the States, in the varying States, that they should be taken into consideration, nevertheless it is a Board that fixes the standards and the Advisory Council again is the Federal Advisory Council; but, above all, when you get down to 751, which is the over-all provision in regard to the Board and to the Council, and the general administrative provisions, it says at the bottom of page 137:

> All functions of the Board

which, of course, would go back and include section 711, the one you read from,

> shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

That is correct; is it not?

Dr. MEYER. That is correct, sir.

Senator DONNELL. Now, Doctor, you refer in your statement to the charge that an overwhelming majority of American physicians are opposed to national health insurance, and you say it is impossible to substantiate such a conclusion.

Is there any doubt at all as to the fact that the overwhelming majority of American physicians are opposed to national health insurance? Do you have the slightest doubt?

Dr. MEYER. I do.

Senator DONNELL. On what do you base your doubt? Do you have any statistics on it that would substantiate any doubt as to the overwhelming majority of American physicians on national health insurance?

Dr. MEYER. I have no statistics specifically on that issue. I would say the burden of proof is on the contention that the overwhelming majority is opposed to it.

What facts and figures are available, Senator?

Senator DONNELL. Well, I will mention one or two.

In the first place, you know the position of the American Medical Association; do you not?

Dr. MEYER. I know the position of the official statement of the American Medical Association.

Senator DONNELL. Well, those official statements are issued as the result of action of the house of delegates of the American Medical Association.

Dr. MEYER. That is correct.

Senator Donnell. And the house of delegates of the American Medical Association, like the house of delegates of the bar association, which latter association, I think, borrowed the idea from the Medical association—that house of delegates is selected from all over the United States and represents very fully and accurately the opinion of the doctors all over the United States. Isn't that true?

Dr. Meyer. I don't know that that is true, and I have my doubts.

Senator Donnell. You do?

Very well. That was the thought—was it not?—in the creation of that house of delegates, to secure a body which would be fairly representative of the opinion of doctors all over the United States.

Dr. Meyer. I trust that was the effort, but the effort alone was not enough.

Senator Donnell. Doctor, you know that the house of delegates is selected by the local organizations all over the United States, the local doctors' societies. You know that; do you not?

Dr. Meyer. I do, sir.

Senator Donnell. Very well.

Now, Doctor, do you know how many members the American Medical Association has and what proportion of doctors of the United States are members of that association?

Dr. Meyer. There are, I think, about 150,000 doctors.

Senator Donnell. About 150,000 doctors in the United States?

Dr. Meyer. I believe that is correct.

Senator Donnell. How many belong to the American Medical Association?

Dr. Meyer. All except—or I should say most, except those that belong to the National Medical Association. I don't know their membership.

Senator Donnell. Do you know approximately, or are you able to estimate approximately how many members the American Medical Association has?

Dr. Meyer. I wouldn't know, Senator; but I would assume that it represented most of the doctors of the country.

Senator Donnell. You don't mean just 51 percent?

Dr. Meyer. No.

Senator Donnell. Out of 150,000, what is your best judgment, or what would you guess would be the figure?

Dr. Meyer. A guess would be 90 percent.

Senator Donnell. That is a guess?

Dr. Meyer. Yes, sir.

Senator Donnell. You are guessing that 135,000 out of 150,000 are in the American Medical Association?

Dr. Meyer. Yes, sir.

Senator Donnell. And the American Medical Association, without any shadow of doubt, has expressed itself time and time again as being opposed to national health insurance; has it not?

Dr. Meyer. That is perfectly true, Senator; but, if you will continue in the discussion, I will try to indicate that however much the effort may have been designed to create the representative body, I say there is doubt—there is doubt in my mind, and I believe legitimate doubt for construing the repeated statements of the official medical opinion as being representative of the vast majority of American physicians. I have indicated to you that in 1948 a rival slate in the

New York County Medical Society election was endorsed by the Physicians Forum. We have some 7,000 doctors, I would say, in the county of New York. The Physicians Forum may number 10 percent, in that county, roughly. Nevertheless, in an election for officers under a secret ballot, the slate endorsed by the Physicians Forum managed to muster 38 percent of the vote.

Now, as I said in my testimony, my written testimony, the issue was not compulsory health insurance; we were simply voting on local issues; we were voting for local officers, and yet, it was quite clear from the propaganda which was put out by the administration, that to them the only issue was compulsory health insurance, that we represented a bunch of foreigners who were threatening to submerge the county medical society and medicine in general under some alien influence, and consequently the fact that we did muster so large a vote, I think in itself is some indication that one cannot say that the vast majority of physicians are opposed to compulsory health insurance.

Senator DONNELL. Doctor, in your own figures there I believe you say, in your statement here, that was in a secret ballot for the election of officers.

Now, you also say:

> It is true, compulsory health insurance was not an issue on the Physicians Forum sponsored platform, yet the propaganda issued by the leaders of the society made it clear that to them it was the sole issue.

Before that, you said:

> In secret ballot for the election of officers, however the minority group succeeded in mustering up to 38 percent of the total vote in 1948, and 1 out of 3 votes cast in 1949.

That would be 33 percent cast in 1949, so you went down between 1948 and 1949, as I see it.

Dr. MEYER. We did.

Senator DONNELL. But, on either of those years——

Dr. MEYER. I would like to explain that.

Senator DONNELL. I would be glad to have you do so, in a minute.

In 1948, 62 percent, on your own basis, in New York County, in this particular election, were opposed to the views of the Physicians Forum.

Dr. MEYER. That is correct.

Senator DONNELL. And 66 percent, or maybe 67 percent, were opposed in 1949, that is correct?

Dr. MEYER. That is correct.

Senator DONNELL. Now, I think that in fairness to you, you should have an opportunity to explain whatever you want to, or make any statement you want to now.

Dr. MEYER. I would like to make simply a parenthetical remark that some of our anticipated support happened to be in Montreal on the day of the election, on account of the convention.

Senator DONNELL. Were any of the opposition up in Montreal also?

Dr. MEYER. A great many of them were at the American Psychiatric Association.

Senator DONNELL. The American Psychiatric Association is very active in the membership of the New York County body of physicians, is it not?

Dr. MEYER. No; I wouldn't say that the association is active.

Senator DONNELL. Well, its members.

Dr. MEYER. We have a few psychiatrists, and I would say a great many New York psychiatrists are sympathetic to the aims of Physicians Forum.

To continue your point just now, would you consider that 62 percent is an overwhelming majority?

Senator DONNELL. I would certainly say it is a majority. Over 60 percent, which is certainly a majority—we have had many Presidents that have not been elected by as much as that, but I want to ask you further, if you think, Doctor, that the proportion of persons that favor compulsory health insurance over the United States, entirely in the little towns, the big towns, and everywhere is as great as the proportion of the Physicians Forum vote was to the total vote in this election that you refer to here.

Dr. MEYER. Speaking only of professional people?

Senator DONNELL. Yes, Doctor.

Dr. MEYER. No; I suppose that that is correct. I suppose that the percentage that we created in the county of New York would not be representative of the medical community at large. I don't know, and I don't believe there is anybody that knows. All I am saying is that when doctors are given an opportunity, without fear of disclosure of their identity, to express their views on this matter, that a surprisingly large number of physicians have supported the organization which I have the honor to represent.

Senator MURRAY. I will have to leave for a short period of time, and will ask you to continue the examination in my absence.

Before leaving, I would like to ask just a few questions, if I may interrupt at this point.

Senator DONNELL. Go ahead.

Senator MURRAY. Doctor, don't you think there has been a considerable change in sentiment among the members of the medical profession in the United States with reference to this subject of compulsory insurance in recent times, in recent years?

Dr. MEYER. I think quite a large number of doctors have grown, or begun to think about this matter, which they had not before.

Senator MURRAY. I found, in my experience in Montana in the last campaign that doctors would come and call on me at my hotel, and discuss the matter with me, and tell me that they were friendly to my program, but they would not be in a position to allow their names to be published; and, I have had the same experience with dentists around the country.

Do you not think that the action of the American Medical Association in discharging Dr. Fishbein is an indication of changing views in the profession? Don't you think it was because of his vehemence in opposition to the compulsory insurance system that made enemies for himself in the profession—that he was just too bitter in his opposition to it?

Dr. MEYER. I think, Senator, that the American Medical Association realized that they had succeeded in antagonizing a great number of American citizens and it became necessary for them to have some kind of a change in their window dressing, and I think that was probably largely responsible for this change. I do not think the basic policy of the American Medical Association toward your bill has changed, nor that their methods of fighting it have changed with the unseating of Mr. Fishbein.

Senator MURRAY. I want to say that I have had a lot of experience with Dr. Fishbein. He has appeared here a great many times and I have had very close contact with him and always found him to be a very fair person in all his conduct toward me. I met him frequently, and I think that he was a very able man and it was his opposition to the bill that made the fight against us so successful. He was simply a very energetic, able man, and carried on a very powerful campaign against the bill, so I was wondering what was the reason for that?

Dr. MEYER. I wouldn't know.

Parallel with something you said, I would like to point out also something, Senator Donnell.

I would like to point out, with Senator Donnell, that I was asked for a statement, I have been asked for a statement on the Truman program from a certain broadcasting company, and on talking to these fellows, they have told me that they have approached various physicians throughout the country and asked for a statement as to whether they opposed or whether they endorsed the program, and those individuals who are repeatedly in agreement with the program have said, "You may use my words, but you cannot disclose my identity."

As I have tried to indicate, it is professionally unhealthy to endorse the health program of the President of the United States.

Senator DONNELL. In connection with Dr. Fishbein, am I correct in understanding——

Senator Murray, would you mind waiting a moment; there is one point I want to ask before you go, in regard to discussing an exhibit.

Senator MURRAY. Yes.

Senator DONNELL. Dr. Meyer, I want to say—if I correctly interpreted the answer to Senator Murray's question—as I understand it, you do not consider that the action taken at Atlantic City with respect to Dr. Fishbein a few days ago indicates any change in the position of the American Medical Association with respect to compulsory national health insurance? Am I correct in so understanding?

Dr. MEYER. That is correct, Senator.

Senator DONNELL. Dr. Fishbein is a man, as Senator Murray indicated, of strong views and an individual type of expression and he aroused some resentment; and, it would appear, would it not, that it was thought advisable if the American Medical Association is to perform the utmost, in its efficiency and effectiveness, that it should not be handicapped by that hostility that people may have had toward Dr. Fishbein.

That is, in your opinion, the principal reason for the change made with respect to him, isn't that true?

Dr. MEYER. My feeling is that the American Medical Association has drawn upon itself certain hostility from many, many aspects of the country; that these hostilities were channelized in two directions, in particular: One, toward the National Physicians Committee; and another in the direction of Dr. Fishbein.

By liquidating both, they have endeavored to render themselves 99 44/100 percent pure in the eyes of the public.

Senator DONNELL. But the American Medical Association, in your opinion, has not changed its position of opposition to compulsory national health insurance?

Dr. MEYER. That is true, sir.

Senator MURRAY. It changed its character. The National Physicians Committee was wholly a propaganda organization and presented false statements and misrepresentations to the public, and the public began to realize the fraudulent character of the program that they were carrying out across the country, isn't that true?

Dr. MEYER. That is true, Senator; but, I think if you were to see some of the material which is at the present time emanating from the Fishbein-less American Medical Association, you would see that the character of the propaganda has not changed.

I will refer specifically to a small pamphlet called the Voluntary Way is the American Way, which shows an eagle perched on the American flag, and the question and answers given here are quite similar in their underlying philosophy and orientation to the kind of material which emanated from the National Physicians Committee.

Senator DONNELL. Was that pamphlet issued by the American Medical Association Committee?

Dr. MEYER. Yes.

Senator DONNELL. I would like to ask that the Doctor furnish a copy and that it be placed in the record of this proceeding at this point.

Senator MURRAY. Will you permit us to have a copy of that? Can you get another copy? I suppose they are plentiful.

Dr. MEYER. They are plentiful, but this is the only one I happen to have with me. And, I have notes on it.

Senator DONNELL. Do you think you could send us a copy? If it is not convenient, I shall ask that the clerk of the committee be requested to secure a copy from a representative of the American Medical Association.

Senator MURRAY. And, I also ask that the clerk select some pamphlets containing contrary views to be presented by other organizations.

Senator DONNELL. That will be perfectly all right, Mr. Chairman.

(The pamphlet referred to is as follows:)

THE VOLUNTARY WAY IS THE AMERICAN WAY

50 QUESTIONS YOU WANT ANSWERED ON COMPULSORY HEALTH INSURANCE VERSUS HEALTH—THE AMERICAN WAY

FOREWORD

Health insurance is here to stay

It is sound and sensible for Americans to protect themselves against the financial shock of accident and illness.

The only question is:

How will you have your health insurance? On a voluntary basis—with sound medical direction?

Or on a compulsory basis—with politicians at the controls?

Here are—

The questions you've been asking—and the factual answers you've a right to know.

WHAT?—WHO?—WHY?

1. Question. What is "compulsory health insurance"?

Answer. It is a multibillion dollar program proposed by the Office of the Federal Security Administrator, which would supplant voluntary health insurance with compulsory health insurance—levying a pay-roll tax to support the new Government-regulated system of medicine.

2. Question. Why is it proposed at this time?

Answer. Government advocates argue that low standards of public health and medical care in America today make Government control imperative.

3. Question. Is it true that America has "low grade" health care?

Answer. No. Among all the great nations, the highest standards the world has ever known in medical care and scientific progress, both in reducing disease and lengthening life—are here in America.

4. Question. Who is for compulsory health insurance?

Answer. The Federal Security Administration.

The President.

All who seriously believe in a socialistic state.

Every left-wing organization in America.

Two specially organized propaganda groups—the Committee for the Nation's Health and the Physicians Forum—whose prime concern is campaigning for compulsory health insurance.

Some AFL and CIO leaders, but labor is divided on this issue. (Most rank-and-file union men are violently opposed to more pay-roll deductions.)

The Communist Party.

Some well-intentioned, but misinformed people who have been led, by the proponents' misuse of facts, to believe that Government control will solve all the country's health problems.

5. Question. Who is against it?

Answer. The General Federation of Women's Clubs (5,000,000 members).

The American Legion.

The American Farm Bureau Federation.

The American Bar Association.

The National Association of Small Business Men.

The United States Chamber of Commerce.

The National Federation of Small Business, Inc.

The National Grange.

The Associated Women, American Farm Bureau Federation.

The American Medical Association.

The American Hospital Association.

The D. A. R. (National).

The Women's Patriotic Conference on National Defense.

National Fraternal Congress of America.

Legislatures of various States.

Governors of the great majority of the States.

Nurses' organizations.

Catholic, Protestant, and other hospital groups.

The American Legion Auxiliary.

Business and professional women's clubs in all parts of the Nation.

Lions, Rotary, and other service organizations.

Various city, State, and district federations of women's clubs.

City and State chambers of commerce throughout America.

The overwhelming majority of home-town newspaper editors, whose first interest is protecting their communities from crackpot schemes.

Hundreds of organizations interested in public welfare, not politics, who have no wish to trade the American medical system for the sorry record that politically controlled medicine has made in every great nation which has tried it—notably Germany, France, Russia, and England.

POCKETBOOK QUESTIONS

6. Question. What is "compulsory" about compulsory health insurance?

Answer. The pay-roll tax is compulsory. There is no escape from it. But there is no compulsion on Government to maintain standards or fulfill promises. That's the joker.

7. Question. Will people who don't wish to use the Government service have to pay the tax?

Answer. Yes. Everybody with a pay check or an income will pay the tax, whether he uses the service or not.

8. Question. Will veterans who already have paid for medical care by their war service, be taxed?

Answer. Yes. Veterans will pay the tax, even though they don't need the service and don't want it.

9. Question. Will members of faith-healing religions be taxed?

Answer. Yes. Millions of members of all faiths whose principles would prevent use of the service, nevertheless will be taxed for it.

10. Question. Will people who already are protected under satisfactory voluntary health plans be taxed?

Answer. Yes. Whether protected under medical-care plans, commercial, industrial, fraternal, or labor plans, they will be compelled to pay the tax for the Government plan.

11. Question. How much will the tax be?

Answer. Sponsors have used various figures. Estimates range from 3 to 10 percent on every pay check up to $4,800, half paid by the employee and half by the employer. The self-employed would pay the whole amount.

12. Question. What does that make the total bill?

Answer. The medical bill of the average family would be doubled, if not trebled. The staggering cost to the Nation has been estimated at from 6 to 15 billion dollars.

13. Question. Why don't the sponsors advise the people honestly and clearly on this all-important matter of cost?

Answer. They know they are apt to be wrong however well they figure. No nation which has tried government-controlled medicine ever has been able to anticipate the cost correctly. In New Zealand, the cost multiplied eight times in 5 years. In England Government medicine has gone $200,000,000 in the red in the past 9 months, grossly exceeding estimates first given the people. And the type of assembly-line service being rendered there would not be tolerated by Americans.

14. Question. Why should the cost, even for second-rate service, run so high?

Answer. Because Government-controlled medicine is political medicine.

In Germany it took one Government employe for every 100 persons insured. At that ratio, America would require a 1,500,000 nonmedical employes—clerks, administrators, bookkeepers, and tax-collectors—on the Federal pay roll siphoning off medical funds before they ever bought the patient care of any kind.

THE "INSURANCE" DELUSION

15. Question. Is compulsory health insurance really "insurance"?

Answer. It is not. And it is gravely unfair to the people to pretend that it is.

Reasons it is not "insurance":

1. Though an arbitrary "premium" is collected, in the form of a pay-roll deduction, benefits are neither specified nor guaranteed. In the exact language of the sponsors, certain services are promised "when funds are available," "insofar as possible," and "when facilities permit."

2. Sound insurance is based on sound actuarial standards—and on contracts clearly setting forth both benefits and costs. Millions of Americans have such guaranties in writing—under voluntary health insurance. But the only guarantee in the compulsory health "insurance" proposal is guarantee of a new payroll tax—the amount unpredictable.

THE BIGGEST HOAX

16. Question. Did the National Health Assembly recommend compulsory health insurance?

Answer. No. After a meeting of the National Health Assembly, the office of the Federal Security Administrator submitted to the President a Report on the Nation's Health and a Ten Year Program. These are the personal reports and recommendations of a Federal office holder. The assembly refused to recommend compulsory health insurance.

17. Question. Does the Report on the Nation's Health give a factual picture of the people's health in America?

Answer. No. This widely publicized report is a hoax. It is a propagandized treatment of a subject far too important for such loose handling by political experimenters. Government agencies are spending untold millions in tax money to spread its erroneous "facts" and false conclusions—forming a Government "lobby" to sell compulsory health insurance to the people of America. Many leaders in good faith, have carefully considered both the report and the compulsory health insurance proposal—only to discover that both are based on badly distorted evidence.

THE DRAFT REJECTION FALLACY

18. Question. What distorted evidence was used?

Answer. Misleading use was made of the United States draft rejection figures, with the sly implication that the rejections would have been fewer under Government-controlled medicine.

19. Question. What is the truth about the draft rejections?

Answer. According to the highly regarded authority of Dr. Maurice H. Friedman, formerly of the University of Pennsylvania Medical School, nearly two-thirds of the total draft rejections were for causes beyond the power of medical treatment to prevent. With the United States Selective Service standards highest in the world, millions of men were rejected for such causes as illiteracy, mental deficiency, venereal disease, defective vision, amputations, heart ailments, color blindness, and deafness.

20. Question. How many 4-F's could medicine have helped?

Answer. Dr. Leonard Rowntree, former Medical Director of Selective Service, has declared that only 6 percent of all the men examined had defects which might have been cured by medical treatment.

21. Question. What do the draft figures mean, then, in respect to measuring the Nation's health?

Answer. The impartial Brookings Institution—which the Government itself engages on important research—says the draft rejection figure "are wholly unreliable as a measure of the health of the Nation."

THOSE "NEEDLESS DEATHS"

22. Question. What about the widely quoted statement of the Federal Security Administration that "325,000 people die needlessly every year"?

Answer. That total is made up of:

Forty thousand deaths from accidents.—The sponsors of compulsory health insurance do not reveal how they will prevent careless driving, falls from ladders, or slips in bathtubs. The National Safety Council, and other safety groups, doing a splendid, practical job of reducing accidents, doubtless would like to know.

One hundred and twenty thousand deaths from communicable diseases.—One of the most brilliant chapters in American medical history is the continual reduction, year-by-year, of deaths from this cause. Other nations seek to emulate that record. The whole world honors and respects it—if the Federal Security Administration does not.

One hundred and fifteen thousand deaths from cancer and heart disease.—In a nation where—during the lifetime of most adults today—the average life expectancy has been increased from 34 to 67 years, that is not surprising. Both are afflictions mainly of old age.

With the most brilliant physicians and scientists in the world devoting more time than ever in history to cancer and heart disease cure, and with greathearted humanitarians giving millions every year to finance the work—the extravagant promises of a political bureau in Washington in such matters appear to the average American as the most flagrant political opportunism.

Thirty thousand infant and maternal deaths and 20,000 deaths from "other causes."—Just how these would be prevented under compulsory health insurance is not divulged. It is a cruel deception to imply that a political bureau can make greater progress than scientific medicine in coping with health problems.

IS IT SOCIALIZATION?

23. Question. Why is compulsory health insurance called socialized medicine?

Answer. Because the Government proposes to: Collect the tax; control the money; determine the services; set the rates; maintain the records; direct both the citizen's and the doctor's participation in the program; assume control not only of the medical profession, but of hospitals—both public and private—the drug and appliance industries, dentistry, pharmacy, nursing, and allied professions; dominate the medical affairs of every citizen—through administrative lines from the central government in Washington—down through State, town, district, and neighborhood bureaus.

YOU MAY BE NEXT

24. Question. Would socialized medicine lead to socialization of other phases of American life?

Answer. Lenin thought so. He declared: "Socialized medicine is the keystone to the arch of the socialist state." Today, much of the world has launched out on that road. If the medical profession should be socialized because people need doctors, why not the milk industry? Certainly, more people need milk every day than need doctors. On the same erroneous premise, why not the corner grocery? Adequate diet is the very basis of good health. Why not nationalize lawyers, miners, businessmen, farmers? Germany did, Russia did. England is in the process.

25. Question. What does this prove?

Answer. It proves that America is the last great free nation on earth. It is strong and productive and virile enough today, under its own system, to shoulder the burdens of the rest of the world. It proves that the greatest error in all history would be for America to start borrowing the unsuccessful systems of foreign countries which today are on their feet only because the American system is strong enough to support them.

26. Question. How do movements like compulsory health insurance get started?

Answer. Because people of short memory for American history, and shorter vision for the American future, proclaim that increasing political control of American lives and work is a "trend." It is a trend only so long as energetic people who like the American way of life above all others, look the other way when political controls like compulsory health insurance are proposed.

LET'S LOOK AT THE RECORD

27. Question. Where did compulsory health insurance start?

Answer. Germany had the first and strongest all-inclusive program. If the world needs proof of what regimentation and political domination of doctors and scientists can do, even in this modern world—the Nuremburg trials have supplied it. The medical men of Germany, once honored for their humanitarian progress, have not yet been admitted back into the World Medical Society.

28. Question. Why do doctors generally oppose compulsory health insurance?

Answer. Because it is compulsory regimentation, and because the historical record of every great country to try politically controlled medicine, is a record of deterioration of medical education, training and research; degeneration of medical standards, and of medical care; steady decline of the people's health.

29. Question. Why does medical care suffer under political medicine?

Answer. Because doctors are responsible to politicians first and their patients second. They are overwhelmed with paper work and red tape. They are swamped with patients who do not need care, as well as those who do. In England today, for example, many physicians are seeing as many as 80 patients in the 4 hours of office practice, according to the authority of Elizabeth Wilson, American writer and actuary who has studied the British system first-hand. That permits about 3 minutes per patient for diagnosis and treatment. Such a system would scarcely suit Americans.

30. Question. Why are some prominent British visitors here reluctant to comment on how socialized medicine is working in England?

Answer. Criticism of their Socialist Government would jeopardize American loans to that Government. Every thinking American is aware of this.

31. Question. Under compulsory health insurance, may a patient choose his own doctor?

Answer. The compulsory system inevitably means the panel practice system, under which doctors are assigned to patients and patients to doctors. There is no guaranty of freedom of choice. Further, if the doctor desired and obtained were not on the Government panel, the patient would pay both his doctor's bill for service, and the Government's bill for no service. Proponents of compulsory health insurance in this country promise that patients would be free to choose their own doctors. But this same promise was made in England. It is an empty promise, never kept.

YOUR HEALTH—PUBLIC OR PRIVATE?

32. Question. Under compulsory health insurance, do private medical matters remain private?

Answer. It is proposed to set up "local administrative boards" as in England—to assure "local control." In England, the talk and gossip among members of the local boards has been bitterly protested by the British Housewives League. Under this system your health record becomes a public record—and privacy goes out the window.

33. Question. Is there actually a doctor shortage?

Answer. Yes. In some areas there is a scarcity of doctors—just as there is a shortage of other desirable services and facilities. But such shortages are not relieved by destroying incentive and by drafting doctors and ordering them to specified territories. Nor are new doctors created overnight by waving a political wand. Doctors are created by 10 or 12 years of extensive, expensive training. In many States, the medical profession itself contributes to the training of young doctors, in exchange for their voluntary location where medical personnel is needed.

The prospect of a Government-controlled medical system has dampened the enthusiasm of many brilliant, independent young people who want a chance to make their own, unregimented way in medicine. The absurdity of advancing compulsory health insurance as a "cure" for the doctor shortage is attested by the 1948 report of the World Medical Association which discloses that the United States, under the American system of medical practice, has more doctors in proportion to population than any Nation which has adopted a system of Government medicine. This country actually has more doctors, proportionate to population, than any other country in the world, except for Palestine, where there are great numbers of refugee physicians from Central Europe. (No postwar statistics are available for Soviet Russia or Germany, but both countries lag far behind in medical personnel.)

The World Medical Association reports as follows:

Country	Total number of doctors	Doctors per 100,000 population	Country	Total number of doctors	Doctors per 100,000 population
United States	197,605	140	Norway	2,900	93
Great Britain	55,771	114	Netherlands	8,000	89
Denmark	4,250	105	Czechoslovakia	9,300	78
Canada	11,901	104	France	30,000	75
New Zealand	1,800	103	Eire	2,000	67
Australia	7,137	95	Bulgaria	4,563	65
Switzerland	3,806	95	Finland	1,737	45
Sweden	6,360	95	China	20,000	4
Spain	25,142	93			

34. Question. Have we actually any health problems?

Answer. Yes. There are many ahead to be solved—just as there are economic, social, and political problems yet to be solved. The Federal Security Administrator is not as aware of the goals ahead as the average American doctor—because the average doctor is constantly striving toward those goals, and because of that striving, American health and medical care lead the world today.

35. Question. Can doctors solve all our health problems?

Answer. No. Obviously, many of those cited by the Federal Security Administration are social and economic—not medical. Many have their roots in malnutrition, overcrowding, poor living conditions, lack of health education, and indolent attitudes in some sections toward such education.

36. Question. Whose responsibility are those problems?

Answer. All of us must help in meeting them. They are community problems—and many communities, in cooperation with Government, private, and public agencies are hard at work on their solution. The attempt to shift responsibility onto the shoulders of the medical profession, is as absurd as it would be to blame teachers or lawyers because the Federal Security Administration hasn't yet been able to solve the problems of the unemployed, the aged, or the indigent.

37. Question. What is the proper responsibility of doctors in public health matters?

Answer. For years the doctors of America and the allied professions have worked together toward great public health goals—goals which the socializers apparently have just discovered. They have conquered scourges like diphtheria, scarlet fever, cholera, smallpox, and typhoid fever, that once held whole nations in dread epidemic. Even pneumonia is well on the way out as a killer, due to medical progress.

In our own lifetime, medical science has extended the average man's days on earth by 33 years. In the broad field of public health, under the auspices of State and local medical societies and the American Medical Association, doctors are working diligently, with every interested agency, to improve and extend: Nursing, dental, and medical training institutions, facilities, and personnel; hospital, clinical, diagnostic, and scientific research facilities; community health centers and local health units; laboratory services and mental hygiene clinics; care for infants, mothers, the aged and the chronically ill; voluntary health insurance facilities and benefits to take the economic shock out of illness. The unflagging humanitarian and scientific achievements of men and women under the American medical system are bringing a sick world new hope.

38. Question. To the average family, are medical bills the biggest problem?

Answer. No. The most critical problem in the average household today is not the medical bill, but the tax bill. Medical care costs the average American family about 4 percent of income, according to the Brookings Institution. But tax bills take from 20 to 30 percent of family income. If the unreasonable costs of Government were reduced, the American people could afford better health standards—better food and better housing. But compulsory health insurance would add to the burden, rather than relieving it.

WILL VOLUNTARY INSURANCE HELP?

39. Question. Is it true that "health insurance is coming"?

Answer. It is here. The only question is: How will you have it? On a voluntary basis with doctors in charge—or on a compulsory basis with politicians in control?

40. Question. Has voluntary health insurance been tried extensively?

Answer. Yes. Doctors discovered long ago that most families need some means of cushioning the economic shock of sudden illness or accident. State medical societies started studying, approving, and initiating sound nonprofit medical-care plans over a decade ago. Hospital plans—and insurance company plans—also are operating successfully in every section of the country. Today, voluntary plans are providing budget-basis hospital, medical, and surgical care for millions.

41. Question. What has the experience proved?

Answer. That there is nothing Government can do in the field of health insurance which the private citizen can't do better for himself—and at far less cost!

42. Question. How many different plans are there?

Answer. Hundreds. There are plans to fit every individual or family need, and to fit every budget. There are approximately 100 nonprofit, prepaid medical-care plans sponsored by doctors. There are hundreds of voluntary accident and health plans, sponsored by insurance companies. And there is the great Blue Cross hospital system, with more than 32,000,000 members. There are industrial, fraternal, and labor plans, and private group clinics. There are scores of types of hospital, surgical, and medical coverage. The choice is broad. And the competition between groups for lower rates and expanded benefits is both healthy and American.

43. Question. How many people are protected under voluntary health insurance?

Answer. More than 55,000,000 are protected under hospital, surgical or medical-care plans. That is more than a third of the entire population, budgeting its own health protection.

44. Question. Are the voluntary plans giving satisfaction?

Answer. The positive proof is in their steady rise in popularity. In the past 2 years, more than 15,000,000 additional people have been insured. The growth of the voluntary plans has been one of the most rapid and spectacular economic developments in our time.

CAN WE AFFORD IT?

45. Question. Can the average worker afford voluntary health insurance?

Answer. Yes. If a family can afford a daily pack of cigarettes or a Saturday night movie, that family can afford to buy voluntary health insurance. The monthly cost is about the same. If a family cannot afford this protection it certainly cannot afford to have another tax—at least twice as high as a voluntary health insurance premium—deducted from its income.

46. Question. What does voluntary health insurance cost?

Answer. An average, fully-approved plan, for full coverage—surgical, medical, and hospital protection—charges $2.50 for an individual and $5.50 for a family, irrespective of size. Rates vary from State to State; this is the national average.

47. Question. May a person improve his voluntary health insurance coverage by "shopping around"?

Answer. Yes. He may "shop around" among types of service as freely as he shops for brands of food, or shoes, or make of car. Improvements in services and extensions of benefits keep the voluntary plans in healthy competition, both from the standpoint of service rendered, and cost to the insured. This is the American way—a wholly impossible way under compulsory health insurance, where only one system is available, and that system is regimented under Government monopoly and centralized control.

48. Question. Are the doctors of America "lobbying" against compulsory health insurance?

Answer. The medical profession—together with hundreds of other professions and organizations which recognize in Government-controlled medicine a step toward regimentation—are presenting their case before the bar of public opinion in every community in the Nation. One of our most sacred rights is the right of petition—and this case is being carried direct to the people.

If that is "lobbying"—then the greatest "grass roots lobby" in history is in progress today in America. It is "lobbying" in the finest American tradition.

THE ANSWER

49. Question. What can the average citizen do to help?

Answer. He should make it his business as a responsible citizen to find out the facts.

50. Question. What then?

Answer. He should discuss the matter with others in his community who have the public welfare at heart—leaders in business, agriculture, clubs, veterans' organizations, church groups, clergymen, local editors, and others. He should write to his Congressman and Senators in Washington, and his State legislators, telling them he wants no part of compulsory health insurance in the United States.

Compulsory health insurance means:

- Second-rate medical care.
- Decline of medical education, training, research.
- Invasion of personal privacy in medical matters.
- Political control of medical systems.
- A growing political hierarchy of Government administrators.
- Constantly mounting pay-roll taxes.
- Extension of controls over other professions.
- On standardized brand of medicine for America—the Government-controlled brand.

Voluntary health insurance means:

- Guaranteed protection from financial shock in time of illness.
- High-quality medical care, free from political red tape or interference.
- Low budget-basis cost and certain knowledge of the costs.
- Absolute guarantee of the benefits.
- Free choice of service.
- Free choice of doctor.
- Freedom from new pay-roll taxes.
- Privacy in personal medical affairs.
- The right to spend the medical dollar as desired.
- Maintenance in America of the world's highest medical standards.

THIS IS THE STORY OF COMPULSORY HEALTH INSURANCE VERSUS VOLUNTARY HEALTH INSURANCE

There isn't much doubt where the majority of Americans will stand * * * once the facts are known.

In America, we don't like compulsion. We don't like regimentation. In America, we like liberty.

The voluntary way is the American way—and most Americans instinctively know that.

But America needs to be alerted. This country alone, among all the great nations of the world, still has incentive and opportunity and a great measure of individual liberty. If the fight against state socialism is lost here, the light of liberty will go out all over the world.

That is the critical decision which we face—and compulsory health insurance is one of the final, irrevocable steps toward a regimented state.

If doctors lose their freedom today—if their patients are regimented tomorrow, who will be next? You will be next. There is no escape from that conclusion.

Compulsory health insurance isn't just a threat to health; it is a threat to freedom.

No matter how busy you are write your Congressman—and do it now. Help strike a blow for freedom that will ring throughout America.

NATIONAL EDUCATION CAMPAIGN, AMERICAN MEDICAL ASOCIATION

1 North La Salle Building, Chicago, Ill.

(Subsequently Senator Murray submitted the following pamphlet for inclusion in the record:)

COMMITTEE FOR THE NATION'S HEALTH,
Washington, D. C., July 15, 1949.

HON. JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: We understand that in the course of the hearings before your subcommittee an AMA pamphlet entitled "The Voluntary Way Is The American Way" was inserted in the record.

Since the pamphlet sets forth 50 questions on the issue of compulsory health insurance and since, with few exceptions, the AMA has misrepresented the facts, we respectfully ask that the attached compilation also be inserted in the record. In this we have taken the questions as stated by the AMA, given the substance of their replies to the questions, and the true answers from the point of view of the committee for the Nation's health.

Sincerely yours,

CHAT PATERSON, *Executive Director.*

FIFTY QUESTIONS ON COMPULSORY HEALTH INSURANCE

THE AMA SAYS—	THE TRUTH IS—

1. What is "compulsory health insurance"?

A multibillion dollar proposal of the Federal Security Administrator to supplant voluntary health insurance.	It is a pay-as-you-go plan to make good medical care available to everyone. It was proposed before the Federal Security Agency was even born.

2. Why is it proposed at this time?

Government advocates argue that low standards of public health and medical care in America today make Government control imperative.	Our high-quality medical care is priced beyond the reach of most Americans. That is why hundreds of organizations and millions of people—not the Government—propose it at this time.

3. Is it true that America has "low grade" health care?

No. Among all the great nations, the highest standards the world has ever known in medical care and scientific progress, both in reducing disease and lengthening life—are here in America.	American standards lag behind other nations in some important respects. Moreover, our people do not enjoy the good standards of health that modern medical science warrants.

4 and 5. Who is for compulsory health insurance and who is against it?

The President.	The President of the United States.
The Federal Security Administration.	Many Senators and Representatives.
The Committee for the Nation's Health and the Physicians Forum.	The Committee for the Nation's Health—national nonpartisan organization of physicians and citizens.
The Communist Party, left-wing organizations and Socialists.	The Physicians Forum and many individual physicians.
Labor is divided on this issue.	The American Federation of Labor, the Congress of Industrial Organizations, and the great independent labor organizations.
Well-intentioned, but misinformed people. The AMA claims these national organizations are opposed to national health insurance: The DAR; the American Medical Association; the United States Chamber of Commerce; the General Federation of Women's Clubs; the American Legion; the American Legion Auxiliary; the American Farm Bureau Federation; the American Bar Association; the National Association of Small Business Men; the National Federation of Small Business, Inc.; the National Grange; the Associated Women, American Farm Bureau Federation; the American Hospital Association; the Women's Patriotic Conference on National Defense.	The American Medical Association is writing off as "misinformed" the millions of people who belong to the following national organizations which, after careful study, have endorsed national health insurance: American Association of Social Workers; American Association of Medical Social Workers; American Association of Psychiatric Social Workers; American Federation of Labor; American Jewish Congress; American Home Economic Association; American Public Health Association; Americans for Democratic Action; American Veterans Committee; Brotherhood of Railroad Trainmen; Central Conference of American Rabbis; Congress of Industrial Organizations; Committee of Physicians for the Improvement of Medical Care; Cooperative Health Federation of America; Cooperative League of the U. S. A.; Council for Social Action of the Congregational Christian Churches; Methodist Federation for Social Service; International Association of Machinists; National Association for the Advancement of Colored People; National Association of Colored Women; National Association of Colored Graduate Nurses; National Consumers League; National Council of Jewish Women; National Council of Negro Women; National Dental Association; National Farmers Union; National Federation of Settlements; National Association of Consumers; National Women's Trade Union League of America; Physicians Forum.

6. What is "compulsory" about compulsory health insurance?

The pay-roll tax is compulsory.	The pay-roll tax is compulsory.

7. Will people who don't wish to use the Government service have to pay the tax?

Yes.	Yes. We support public schools whether our children use them or not.

8. Will veterans who already have paid for medical care by their war service be taxed?

Yes. Veterans will pay the tax, even though they don't need the service and don't want it.	Few veterans today are entitled through public funds to the complete medical care for themselves and their families that they need and deserve. Under national health insurance they could afford adequate medical care for themselves and their dependents. If special treatment for veterans and their dependents is desirable, Government can, as provided for in the national health insurance bill, buy into the insurance plan so as to relieve them of any share in the pay-roll tax.

9. Will members of faith-healing religions be taxed?

Yes. Millions of members of all faiths whose principles would prevent use of the service, nevertheless will be taxed for it.	Yes; if they are eligible. They will be required to contribute just as many people pay taxes to support public education, but because of their principles or particular faith send their children to private sectarian schools.

10. Will people who already are protected under satisfactory voluntary health plans be taxed?

Yes.	Yes; but they would not pay twice. People who choose to receive their care through certain voluntary health service plans could continue to do so. They would contribute toward the national health insurance fund which in turn would reimburse a plan to which they belong, just as it would pay individual doctors and hospitals.

11. How much will the tax be?

Estimates range from 3 percent to 10 percent on every pay check up to $4,800, half paid by the employee and half paid by the employer. The self-employed would pay the whole amount.	Employed persons would pay 1½ percent of their wages or salaries, employers would match the 1½ percent contribution of employees, and the self-employed would contribute 2¼ percent of earnings. In each case, the percentage would apply only on the first $4,800 of earnings. In addition, Government would contribute up to 1 percent of the national pay roll.

12. What does that make the total bill?

The medical bill of the average family would be doubled, if not trebled. The staggering cost to the Nation has been estimated at from $6,000,000,000 to $15,000,000,000.	The out-of-pocket cost to the average worker would be considerably less than for most workers at present. For example, a worker earning $20 a week would contribute 30 cents a week, or $15.60 a year; the worker earning $75 a week would contribute $1.02 a week, or $53 a year. In return, the insured person and his dependents would be covered for all services of physicians and specialists in the home, doctor's office, or hospital; hospital care up to 60 days, expensive drugs and appliances, and some dental and home-nursing care.

	The over-all cost to the Nation, roughly $6.000,000,000, would be considerably less than the billions of dollars now lost in potential production and wages as a result of sickness and disability; and, it represents little more than is now spent for inadequate and poorly distributed medical care.

13. Why don't the sponsors advise the people honestly and clearly on this all-important matter of cost?

They know they are apt to be wrong however well they figure. No nation which has tried Government-controlled medicine ever has been able to anticipate the cost correctly. In England government medicine has gone $200,000,000 in the red in the past 9 months.	They have, but the AMA has repeatedly distorted their statements. Of course, the costs of health-service systems in other countries have risen as the scope of services and number of people covered has been expanded. In England, the first-year deficit is simply an indication of the accumulated neglect of health which has proven greater than ever anticipated.

14. Why should the cost, even for second-rate service, run so high?

Because government-controlled medicine is political medicine. In Germany it took 1 government employee for every 100 persons insured. At that ratio, America would require a million and a half nonmedical employees—clerks, administrators, bookkeepers, and tax collectors—on the Federal pay roll, siphoning off medical funds before they ever bought the patient care of any kind.	Disparaging statements alleging "second-rate" care or that the quality of care has deteriorated under government-initiated health programs in European countries have simply not been substantiated. In fact, some of the AMA's charges have been countered by leaders of the medical professions in those countries. In 1946, and again in 1948, Dr. Charles M. Hill, secretary of the British Medical Association, protested to the AMA against these allegations which he termed a "gross libel" on the British medical profession. The correct statement of facts regarding the number of administrative employees under established European systems is more nearly 1 to every 2,000 persons rather than 1 to ever 100. We estimate the administrative costs to be only 5 to 7½ percent of benefits, which is far less than the administrative costs of any of the existing voluntary health insurance plans.

15. Is compulsory health insurance really "insurance"?

It is not. Reasons it is not "insurance": (1) Though an arbitrary "premium" is collected, in the form of a pay-roll deduction, benefits are neither specified nor guaranteed; (2) sound insurance is based on sound actuarial standards—setting forth both benefits and costs.	National health insurance is a form of social insurance similar to old-age and survivors' insurance. It differs from commercial insurance inasmuch as premiums are geared to income and ability to pay rather than being fixed in proportion to benefits given and size of family.

16. Did the National Health Assembly recommend compulsory health insurance?

No.	Nobody has ever claimed that it did.

17. Does the "Report on the Nations' Health" give a factual picture of the peoples' health in America?

No. This widely publicized report is a hoax. It is a propagandized treatment of a subject far too important for such loose handling by political experimenters.	The "Report on the Nation's Health" is a factual report to the President of the United States compiled and submitted by a responsible official of Government appointed by the President and approved by the United States Congress. Every stateemnt of fact can be documented.

18. What distorted evidence was used?

Misleading use was made of the United States draft rejection figures, with the sly implication that the rejections would have been fewer under Government-controlled medicine.	The draft rejection figures were quoted as released by Selective Service. The rejections were made on the basis of standards drawn up by American doctors to meet American needs.

19. What is the truth about the draft rejections?

According to Dr. Maurice H. Friedman, formerly of the University of Pennsylvania Medical School, nearly two-thirds of the total draft rejections were for causes beyond the power of medical treatment to prevent.	But what about the other one-third? One-third of 5,000,000 is well over a million and a half, or about 100 divisions.

20. How many 4–F's could medicine have helped?

Dr. Leonard Rowntree, former Medical Director of Selective Service, has declared that only 6 percent of all the men examined had defects which might have been cured by medical treatment.	Dr. Rowntree estimated "conservatively" that 700,000, or 16 percent, of the 4,200,000 rejectees had remedial defects. If the "only 6 percent"—the proportion of men with remedial defects among all those examined—were applied to the population at large, that would be 9,000,000 with defects which might be cured by medical treatment.

21. What do the draft figures mean, then, in respect to measuring the Nation's health?

The draft rejection figures are wholly unreliable as a measure of the health of the Nation.	The draft rejection figures certainly indicate that we are not doing nearly as much as we might with the knowledge and skills we have.

22. What about the widely quoted statement of the Federal Security Administration that "325,000 people die needlessly every year"?

That total is made up of 40,000 deaths from accidents; 120,000 deaths from communicable diseases; 115,000 deaths from cancer and heart disease; 30,000 infant and maternal deaths, and 20,000 deaths from "other causes."	No one can seriously doubt that we have the knowledge and skills to prevent the thousands of needless deaths that occur annually. Nor is there any doubt that it takes money to carry on education and research programs necessary to aid in the prevention of disease and death or that it takes money to care for sickness.

23. Why is compulsory health insurance called "socialized medicine"?

Because the Government proposes to collect the tax; control the money; determine the services; set the rates; maintain the records; direct both the citizen's and the doctor's participation in the program; assume control not only of the medical profession, but of hospitals—both public and private—the drug and appliance industries, dentistry, pharmacy, nursing and allied professions; dominate the medical affairs of every citizen—through administrative lines from the central Government in Washington—down through State, town, district, and neighborhood bureaus.	To substitute emotion for reason and to frighten the American people. We are for national health insurance because we are opposed to a system of socialized medicine. The provisions of our national health-insurance bill belie the assertions of Government control and domination over the lives and livelihoods of patients and physicians.

24. Would socialized medicine lead to socialization of other phases of American life?

Lenin thought so. He declared: "Socialized medicine is the keystone to the arch of the Socialist state."	Is Lenin AMA's authority? He is not ours.

25 What does this prove?

It proves that America is the last great free Nation on earth. It is strong and productive and virile enough today, under its own system, to shoulder the burdens of the rest of the world. It proves that the greatest error in all history would be for America to start borrowing the unsuccessful systems of foreign countries which today are on their feet only because the American system is strong enough to support them.	America's greatness needs less proving than improving.

26. How do movements like compulsory health insurance get started?

Because people of short memory for American history, and shorter vision for the American future, proclaim that increasing political control of American lives and work is a "trend."	By failure of the Robin Hood System of medicine—that of soaking the rich to give charity care to the poor—to meet the needs of the vast majority of self-reliant and self-supporting people for adequate medical care.

27. Where did compulsory health insurance start?

Germany had the first and strongest all-inclusive program.	The first instance that we know of where the principle of compulsory health insurance was adopted was in 1798 when the Congress of the United States established, upon the recommendation of Alexander Hamilton, a system of compulsory sickness insurance for our merchant seamen. This was the beginning of the United States Public Health Service.

28. Why do doctors generally oppose compulsory health insurance

Because it is compulsory regimentation, and because the historical record of every great country to try politically controlled medicine is a record of deterioration of medical education, training and research, degeneration of medical standards, and of medical care, and steady decline of the people's health.	An ever-growing number of doctrs are for national health insurance despite the AMA's stand—others have been influenced by the hysterical misinformation contained in such propaganda pieces as this pamphlet. Moreover, organized medicine seeks to "discipline" doctors who openly support national health insurance.

29. Why does medical care suffer under political medicine?

Because doctors are responsible to politicians first—and their patients, second. They are overwhelmed with paperwork and red tape. They are swamped with patients who do not need care, as well as those who do.	This is a loaded question. No one is proposing a system of "political medicine." But the implication that doctors would, under health insurance, be "responsible to politicians first—and their patients second" should certainly be resented most by the doctors themselves.

30. Why are some prominent British visitors here reluctant to comment on how socialized medicine is working in England?

Criticism of their Socialist government would jeopardize American loans to that Government.	Most prominent British visitors, and particularly British doctors, have commented freely on how the British health service plan is working. Their comments have been overwhelmingly favorable.

31. Under compulsory health insurance, may a patient choose his own doctor?

The compulsory system inevitably means the panel practice system, under which doctors are assigned to patients and patients to doctors. There is no guaranty of freedom of choice.	The bill specifically states "persons and their dependents * * * shall be assured full freedom to choose their physicians and to change their choices as they may desire." There is no provision for assignment of patients to physicians, nor will there be any limitation on the number of patients a doctor may serve unless the physicians themselves decide that a limitation is essential to protect the quality of care.

32. Under compulsory Health Insurance, do private medical matters remain private?

Under this system your health record becomes a public record—and privacy goes out the window.	The bill specifically provides for "nondisclosure of information" and for holding confidential the private nature of medical records and the relationship between doctor and patient. Severe penalties are set forth for violation of any such confidence.

33. Is there actually a doctor shortage?

Yes.	Yes. One part of our national health program on which the AMA is cooperating is that which calls for vastly expanding our medical education system so that in a relatively few years hence we will have a greater supply of doctors.

34. Have we actually any health problems?

Yes.	Yes; and the greatest one is paying for medical care.

35. Can doctors solve all our health problems?

No.	No.

36. Whose responsibilities are those problems?

All of us must help in meeting them.	Yes; the responsibility is a social one involving the total community.

37. What is the proper responsibility of doctors in public health matters?

For years the doctors of America and the allied professions have worked together toward great public health goals.	Of course the medical profession should work toward great public health goals. The sponsors of national health insurance have always been the first to applaud American doctors for their achievements. But to make laboratory gains beneficial realities for all the people, the medical profession must grant to the consumers of medical care their right to exercise their responsibilities with respect to the economics of medical care.

38. To the average family, are medical bills the biggest problem?

No.	It depends on the family and its state of health. But medical bills can and have been for many a family. According to the AMA's own estimates, it can be said that today 80 percent of the American people cannot afford all the medical care that they might need at a particular time.

39. Is it true that "health insurance is coming"?

It is here. The only question is: How will you have it? On a voluntary basis with doctors in charge—or on a compulsory basis with politicians in control?	Judging from the mounting support for national health insurance among the people in the country, it is coming.

40. Has voluntary health insurance been tried extensively?

Yes. Doctors discovered long ago that most families need some means of cushioning the economic shock of sudden illness or accident. State medical societies started studying, approving, and initiating sound nonprofit medical-care plans over a decade ago.	Yes. Voluntary health insurance has been tried extensively and over a long period of time. The consumers of medical care recognized the value of prepaid insurance long before the doctors of this country did. The AMA itself opposed all voluntary health insurance plans in the early history of this movement and, in fact, up until only a few years ago.

41. What has the experience proved?

That there is nothing Government can do in the field of health insurance which the private citizen can't do better for himself—and at far less cost.	After nearly a century of experience, voluntary health insurance has failed to provide adequate medical care at low-enough rates to satisfy a majority of Americans.

42. How many different plans are there?

Hundreds. There are plans to fit every individual or family need, and to fit every budget.	Few of the many voluntary health insurance plans offer full protection and at a cost that everyone can afford.

43. How many people are protected under voluntary health insurance?

More than 55,000,000 are protected under hospital, surgical, or medical-care plans. That is more than a third of the entire population, budgeting its own health protection.	Only about 2½ percent of the population enjoys anything like the comprehensive protection that national health insurance offers. The AMA's figure is misleading. The question should be how many people have how much or how little protection. Actually, 27,000,000 people have insurance only for doctors' services in a hospital and hospitalization; 27,000,000 more have hospitalization insurance only; 86,000,000 Americans have no health insurance at all. The significant fact is that all of the voluntary health insurance plans together meet only about 10 percent of the medical and hospital bills paid by the American people.

44. Are the voluntary plans giving satisfaction?

The positive proof is in their steady rise in popularity. In the past 2 years, more than 15,000,000 additional people have been insured. The growth of the voluntary plans has been one of the most rapid and spectacular economic developments in our time.	The voluntary health insurance plans give some measure of satisfaction to some people. The growth in membership over the past 2 years is largely proof of the fact that people want to be able to repay their medical-care costs. However, the amount of dissatisfaction with the limitations of voluntary insurance has contributed to the steadily increasing demand for a national program of health insurance which would make use of all the advantages and none of the disadvantages of voluntary plans.

45. Can the average worker afford voluntary health insurance?

Yes. If a family can afford a daily pack of cigarettes or a Saturday night movie, that family can afford to buy voluntary health insurance.	No; the average worker cannot afford to pay for limited voluntary insurance and then in addition to face the cost of care not provided for under these plans. The average industrial worker in the high-income States earns about $52 a week. To get comprehensive voluntary health insurance, he would have to pay at least $12 a month for himself and his family as compared with a contribution of only $3.38 under national health insurance.

46. What does voluntary health insurance cost?

An average, fully approved plan, for full coverage—surgical, medical, and hospital protection—charges $2.50 for an individual and $5.50 for a family, irrespective of size. Rates vary from State to State—this is the national average.	A typical voluntary health insurance plan described by the director of the Blue Cross-Blue Shield Commission is limited in what it offers and still costs a family $80 to $85 a year. That is $6.66—$7 a month—roughly 20 percent above the AMA's figure. And it is much more than the out-of-pocket cost of national health insurance will be to the average family.

47. May a person improve his voluntary health insurance coverage by "shopping around"?

Yes. He may "shop around" among types of service as freely as he shops for brands of foods, or shoes, or make of car.	Yes; if he has the money to do so. Under national health insurance he would get a better bargain and still be free to choose among several competing voluntary plans from which he wishes to receive his services. Moreover, he will be free to change that choice.

48. Are the doctors of America "lobbying" against compulsory health insurance?

The medical profession — together with hundreds of other professions and organizations which recognize in Government-controlled medicine a step toward regimentation—are presenting their case before the bar of public opinion in every community in the Nation.	Yes; with a multimillion dollar fund, paying, among other, $100,000 a year to their two chief lobbyists, and underwriting the costs of a campaign of misrepresentation.

49. What can the average citizen do to help?

He should make it his business as a responsible citizen to find out the facts.	He should make it his business as a responsible citizen to find out the facts. He can acquaint himself with both sides of the issue by writing to the Committee for the Nations' Health, 1416 F Street NW., Washington, D. C., and to the American Medical Association, 1 North La Salle Street, Chicago, Ill.

50. What then?

He should discuss the matter with others in his community who have the public welfare at heart—leaders in business, agriculture, clubs, veterans' organizations, church groups, clergymen, local editors, and others. He should write to Congressman and Senators in Washington, and his State legislators, telling them he wants no part of compulsory health insurance in the United States.	If he wants to help bring adequate medical care to all Americans at a cost they can afford and as a right, not as a charity, he should urge his Senators and Representatives to support the national health insurance legislation.

Senator DONNELL. Now, Mr. Chairman, I wanted to ask you, as the chairman of the subcommittee, before you leave—the Doctor referred here to "slanted and biased editorial policy," to quote him, in the American medical press; and, in that connection I wanted to ask him whether or not he has seen an article in the Saturday Evening Post, under date of May 28, 1949, entitled "Do You Really Want Socialized Medicine?"—By Steven M. Spencer.

Dr. MEYER. I have not seen it.

Senator DONNELL. Mr. Chairman, I ask leave to have this article printed in full in the record of this proceeding.

Senator MURRAY. It may be printed in full.

I may have a few articles of my own that I will want in the record.

Dr. MEYER. Before we leave the subject of this small brochure, and the question of the parallels between the techniques employed by the National Physicians Committee in behalf of the American Medical Association, and now the American Medical Association in its expurgated state, I would like to call attention to one question and answer which I think is rather characteristic, although there are many, and I wouldn't burden you with all, but one in particular I consider to be a slur on the American physician.

Senator DONNELL. Did you say "slur"?

Dr. MEYER. Yes.

> Question. Where did compulsory health insurance start?
> Answer. Germany had the first and strongest all-inclusive program.

Senator DONNELL. That is true, isn't it?

Dr. MEYER. I am going on.

Senator DONNELL. I say, that is true?

Dr. MEYER. That is true.

Senator DONNELL. Go ahead.

Dr. MEYER (reading):

> If the world needs proof of what regimentation and political domination of doctors and scientists can do, even in this world, the Nuremburg trials have supplied it.

Now, I think the implication of this being, or rather without being what we psychiatrists call "paranoid," is quite clear. The implication is that the establishment of compulsory health insurance, and by implication, of the regimentation and political domination, which is implied therein, would encourage the type of perversion of medical science in the hands of American physicians which existed among the physicians of Germany at the concentration camp—in other words, that the simple establishment of compulsory health insurance or any administrative machinery of that sort would produce the kind of physician experimenting on human beings about which we all read in the Nuremburg trials. I think that is a slur not only on the American physicians, but on Americans, in general.

Senator DONNELL. This was issued by the American Medical Association, which contains, you think, about 90 percent of all American physicians?

Dr. MEYER. Well, this is issued in particular by a committee, I presume.

Senator MURRAY. Prepared by a man, or concern?

Dr. MEYER. This is issued by the public relations individuals who are also responsible, and you might write for this one, too, the AMA Campaign Reporter.

Senator DONNELL. Could I see the pamphlet? I want to see the particular sentence you referred to. I would like to ask you one or two questions on that line.

Doctor, you have read this sentence and construed it, as a psychiatrist, to be a slur on doctors; and I want to read the sentence out:

> If the world needs proof of what regimentation and political domination of doctors and scientists can do, even in this modern world, the Nuremburg trials have supplied it.

Don't you understand that what is being attacked there is not the doctors and scientists, but it is the regimentation and political domination of them, and that that is the thing that this answer is designed to criticize and very strongly so, isn't that correct?

Dr. MEYER. I don't get that feeling out of it at all, although that is the implication.

But further, the deeper implication that is given is that an individual, no matter how decent he may be, if he is a decent American physician with fine standards, perfectly ethical, and so on, once you put him under any kind of a system of regimentation, he may very well turn out to become some kind of a beast in his treatment of his fellow man.

I say this may be true of some individuals, but I doubt very much whether it is true of the vast majority of American physicians and American citizens, and as such I consider it to be a slur.

Senator DONNELL. That is a question of construction of the sentence. I will let the sentence stand for itself, and the meaning to be inferred, by those who read it; but, it would seem to me that what is being attacked is regimentation and political domination of doctors and scientists, not domination when they operate, but domination over them, regimentation and political domination, and that is being opposed in heavy type in here, I see in the pamphlet.

I think that is borne out, my construction, by the next question and answer which reads:

> Why do doctors generally oppose compulsory health insurance?
>
> Answer. Because it is compulsory regimentation, and because the historical record of every country to try politically controlled medicine, results in a degeneration of medical standards and a steady decline of people's health.

Thank you for permitting me to use the pamphlet. I don't want to prolong examining you unduly and shall ask you only a few more questions.

I asked you whether or not you were familiar with the operation of the British system. You said you had not been over there. Have you studied the operation of it in recent months?

Dr. MEYER. I have read some material on it.

Senator DONNELL. I would like to ask you whether or not, in the material you have read, you would concur with these two observations which are just taken at random from this article in the Saturday Evening Post of May 28, which I just offered in the record:

> Yet it is highly significant that nearly every one with whom I talked in England had some reservations about the scheme. People felt that too many were abusing it and thus jamming the traffic in the doctors' offices, that many physicians were being overworked and underpaid, that dentist and eyeglass dispensers were making a killing, that the administrative machinery was cumbersome, slow, and inefficient. Even one of the Government's own regional officers remarked that "most people would not be so mad as to take over such a large thing all at once."

And then, further on it says:

> A good many of the British people admit that they bought Bevan's system a bit too hastily, and they now confess to a feeling of disillusion. They had been won over by the bright promises of everything for everybody. Now that the scheme has been in operation almost a year, their enthusiasm has dimmed.

Have you found in your studies anything that tends to corroborate the observations of Mr. Spencer in the Saturday Evening Post?

Dr. MEYER. Quite a few. I would say that some of the observations by Mr. Spencer, I have come across in reading of my own.

I would say further, however, that he expresses the only data which he has been able to gather.

I would also say that within my own reading that it is generally admitted that nobody seriously would consider sacking the British medical system today. I think, considering what our British friends have been through in the past 10 years, that they deserve all of our encouragement and I think that if they are having difficulties, these difficulties are not remarkable, that they are having difficulties in every aspect of their domestic life and considering the ambitiousness of the scheme, that they have done remarkably well in the short time in which this plan has been in operation. I think they deserve our patience and not the kind of blanket condemnation which has appeared from those hostile to the establishment of national health insurance in this country.

Senator DONNELL. You would not regard the Saturday Evening Post as having a slanted and biased policy on this subject, would you?

Dr. MEYER. I don't think I can answer that, Senator.

Senator DONNELL. I would like to emphasize in the record, I am not asking you any questions along this line, but if you want to make any observations, all right.

These further statements appear in that article:

> A miller's wife, formerly a nurse, remarked, "I thought beforehand that nationalization of the hospitals would be good but now that I've seen how it works out, I think I was wrong. * * * The county hospitals are operating 10 automobiles where they were running only 1 before. * * * Everybody feels he must get what he can out of the Government before someone else does."
>
> A woman doctor, brushing a wisp of blond hair out of her eyes as she signed a sheaf of certificates and orders, confessed, "I was for the plan, but now we family doctors seem to be in danger of becoming simply form fillers and traffic officers, shunting people to this hospital or that specialist."

Then further, it says:

> One of England's leading medical scientists, a head of an important Government council, feels so strongly on this point that he told me, "If I were a young man in England today, I would get out and go somewhere else. I don't object to seeing that the poor get enough to eat," he said, "but why should I be taxed to the limit to put bread in the mouth of the employed worker, who should work hard enough and be paid enough so that he can buy his own food without heavy subsidies?" The comment is frequently heard in England that so much subsidizing in destroying the people's initiative.
>
> For the British health program differs in details from the compulsory health-insurance measure of Senators Robert F. Wagner and James E. Murray, and Congressman John Dingell and their cosponsors; the two plans are cut on the same basic pattern. Both spread the wings of Government-directed medicine over all or nearly all of the population. Both lean heavily on Central Government authority. And both are compulsory in that all wage earners and taxpayers must pay for the services, whether or not they approve them or make use of them.

Well, there are numerous other objections set forth that may be emphasized. If you care to make any comment on these, it is all right. If you don't care to, it is all right, Doctor.

Dr. MEYER. I would, Senator, because, as I said, if you talk to the right people, you can always find individuals who will either substantiate or oppose your point of view.

I think for every condemnation of the character that you have read, one can find an espousal of the British system. I might refer to Dr. Bryan W. Dyer, of London, and Dr. Philip H. Peacock, of Glasgow, who stated there are a lot of people who don't like any change whatsoever. There are sharp corners which have yet to be rounded, and red tape is an increasing burden, but the plan will and must work.

They stated that medical treatment is just a facet of a vast scheme.

They stated there has been something of an uproar over spectacles and so forth, but the patients have not been calling doctors out in the night quite as frequently as was anticipated.

I may say also that in general this has proven to be one of the most popular measures that the Labor government has instituted in England. My own reading has convinced me that there is a tremendous popularity of the Labor government's health policy in Britain, and one of the principal objections which the doctors feel today is they are not being paid adequately.

Senator DONNELL. Doctor, a little while ago I was asking you about the Federal Security Administrator under whose supervision and direction this Federal Board performs all of its functions.

In that connection I would like the record to show at this point that this observation of Mr. Spencer in the article in the Saturday Evening Post, is in point:

> Commander in chief of the Government medical system outlined by the new Wagner-Murray-Dingell bill would be the Federal Security Administrator, currently Oscar R. Ewing, a lawyer and the principal Government salesman of the compulsory-insurance idea. The bill sets up a National Health Insurance Board of five members. But it states that all functions of the Board "shall be administered by the Board under the direction and supervision of the Federal Security Administrator,"

and the words "under the direction and supervision" were in italics.

It goes further and says:

> The functions include the making of "all regulations and standards specifically authorized by the bill" and "such other regulations not inconsistent with this title as may be necessary." In other words, the Federal Security Administrator would be the boss, with sweeping powers to regulate and control.

Doctor, is Dr. Boas still quite active in the Physician's Forum? You mentioned he was still the chairman of the organization.

Dr. MEYER. Yes.

Senator DONNELL. He has not testified yet. Are you associated in any way with Dr. Boas, professionally?

Dr. MEYER. No, sir.

Senator DONNELL. Thank you very much for your testimony.

(Article entitled "Do You Really Want Socialized Medicine?" is as follows:)

[From the Saturday Evening Post, May 28, 1949]

DO YOU REALLY WANT SOCIALIZED MEDICINE?

(By Steven M. Spencer)

> Rarely are you asked to make up your mind on an issue that so deeply affects your personal welfare. Here is what you need to know before deciding on the Truman proposal.

For the eighth time in 10 years the American people are being urged to let the Government pay their doctors for them, with money collected from the American people. The system is called compulsory health insurance, and the theory is that everybody who doesn't have enough medical care today will surely have it tomorrow, because the Government will see to it that he does.

Between theory and practice there is a tremendous gap, much of which is currently being filled with arguments. Many of them fall in a familiar groove, but they are pitched this time against a more substantial background than heretofore—namely, the actual experience of 48,000,000 residents of Great Britain under a comprehensive national health service. The scheme entitles everyone in Britain, visitors as well as citizens, to all medical, dental, and hospital care at the expense of the taxpayers.

Curiously, Britain is being called to give testimony for both sides of the American controversy. Many of those who want compulsory health insurance cite the British plan as a shining example for us to follow. Their opponents, including the American Medical Association, point to the same program as a warning of dire things to come if we adopt any Government-directed system and propose, instead, an extension of voluntary health insurance, with financial help from State and Federal Governments.

What is the story? Should Britain's 11 months of nationalized medicine—socialized if you use the broad definition of that term—cause us to embrace or reject the compulsory plan so insistently advanced by President Truman, Federal Security Administrator Oscar R. Ewing, and the Wagner-Murray-Dingell group in Congress? In this article we shall look for an answer by examining the administration's health-insurance plan in the light of the British experience.

The explanation for the two-way character of the British evidence is that, where there are as many people of intelligence and good will as one finds in England, no plan for the care of the sick will be a 100-percent failure—at least not at first. Most people are willing to give it a sporting chance. Even the British doctors, while swearing under their breath—and sometimes audibly—at Minister of Health Aneurin Bevan and the scheme which he and Parliament pushed through over their opposition, are trying sincerely to make it function. And certainly the majority of the working people—whose purchasing power has for years been much below that of Americans at comparable jobs—welcome a form of medical care supported mainly by taxes on the middle- and upper-income groups.

Yet it is highly significant that nearly everyone with whom I talked in England had some reservations about the scheme. People felt that too many were abusing it and thus jamming the traffic in the doctors' offices, that many physicians were being overworked and underpaid, that dentists and eyeglass dispensers were making a killing, that the administrative machinery was cumbersome, slow, and inefficient. Even one of the Government's own regional officers remarked that "most people would not be so mad as to take over such a large thing all at once."

The temptation to buy the whole package at one time is very great in this period of increasing dependence on Government. In fact, the first danger in any proposal for Government medicine lies in the ease with which it can be glamorized. Like the body-building courses that come with a pair of 25-pound dumbells, it looks magnificent on paper. Unfortunately, the result is usually far short of the pictorial promise in the advertisement. The dumbell system has one advantage, though. If, after a few weeks, you are dissatisfied with your rate of deltoid development, you can stow the dumbbells in the attic and forget them. State medicine is not so earily shucked off, once you have installed it.

A good many of the British people admit they bought Bevan's system a bit too hastily, and they now confess to a feeling of disillusionment. They had been won over by the bright promise of everything for everybody. Now that the scheme has been in operation almost a year, their enthusiasm has dimmed.

Three North of England women expressed this reaction in strikingly similar terms. Said a hospital superintendent, "I was for the plan, but this transitional period sometimes makes you wonder if it is worth while." Then she added, "But I do think it will work out eventually."

A miller's wife, formerly a nurse, remarked, "I thought beforehand that nationalization of the hospitals would be good, but now that I've seen how it works out, I think I was wrong. * * * The county hospitals are operating 10 automobiles where they were running only one before. * * * Everybody feels he must get what he can out of the government before someone else does."

And a woman doctor, brushing a wisp of blond haid out of her eyes as she signed a sheaf of certificates and orders, confessed, "I was for the plan, but now we family doctors seem to be in danger of becoming simply form fillers and traffic officers, shunting people to this hospital or that specialist,"

Some of the British criticism of the National Health Service is bound up in a growing dislike of the whole idea of the welfare state, in which food, housing, fuel and now medical care are at least particularly provided by the Government.

One of England's leading medical scientists, head of an important Government council, feels so strongly on this point that he told me, "If I were a young man in England today, I would get out and go somewhere else. I don't object to seeing that the poor get enough to eat," he said, "but why should I be taxed to the limit to put bread in the mouth of the employed worker, who should work hard enough and be paid enough so that he can buy his own food without heavy subsidies?" The comment is frequently heard in England that so much subsidizing is destroying the people's initiative.

While the British health program differs in details from the compulsory health-insurance measure of Senators Robert F. Wagner and James E. Murray, and Congressman John Dingell and their cosponsors, the two plans are cut on the same basic pattern. Both spread the wings of Government-directed medicine over all or nearly all of the population. Both lean heavily on central Government authority. And both are compulsory in that all wage earners and taxpayers must pay for the services, whether or not they approve them or make use of them.

The scope of the new Wagner-Murray-Dingell bill is not quite so broad as that of Bevan's plan, since the former would cover only those under social security, with a few additional categories. But the trend is to broaden social security to take in almost everyone. "We aim to have everyone who is the head of a family become taxable," explains Mr. Dingell, "so that he and all his dependents under 18 would be entitled to benefits. * * * Why, this is the most liberal proposition in the world."

Many of Mr. Dingell's opponents think his bill is far too liberal. Why, they ask, should tax-supported medical care be offered everyone, the $10,000-a-year man as well as the family getting along on $1,500? The coverage of Government medicine is one of the crucial issues of the whole controversy. Both sides agree that no one who needs medical care should be denied it because he is unable to pay. The opponents of compulsory insurance maintain that it is in the American tradition that those who are able to care for themselves and their families should not lean on government for help. The Wagner-Murray-Dingell group maintain it is too hard to determine who is able to care for himself and who isn't, and that the easiest and fairest way is to make medical care freely available to everyone on the basis of compulsory wage deductions.

Mr. Dingell recalls that his own family lacked means for adequate medical care when he was a boy. "I contracted diphtheria," he said, "at a time when it cost $25 a shot for antitoxin. My family couldn't afford that, and I guess I was one of the very few who pulled through without it."

He declares that he has seen people refused admission to hospitals because they had no money, and he cites the case of a man brought in from the street in Detroit with third-degree burns.

"Because no one, including the policeman who brought him in, could insure the fellow's bill," Dingell said, " the patient was turned away from one hospital and had to be carried clear across town to the city receiving hospital. Under a system in which every hospital knew the Government would pay every patient's bill, this would not have happened."

There are doubtless occasional instances of this kind under our present system. Usually they can be blamed on the stupidity or callousness of hospital clerks or attendants. But can a compulsory health insurance insure against stupidity, callousness, poor judgment, or other human failures? It certainly cannot immediately guarantee a hospital bed for everyone who needs it. In spite of pay rises which have brought more nurses into the hospitals of England, the increased demand for hospitalization has made the shortage more acute since the National Health Service began. There are still 60,000 beds closed by lack of staff. In February the London Emergency Bed Service had 185 calls a day for beds, and each day about 50 persons had to be turned down. The London medical committee, in fact, expressed concern over delay in admitting patients with acute disorders and worried about reports of "many patients who have died, but whose lives might have been saved if energetic action had been taken." Serious illness was no more prevalent than before the Minister of Health took over the hospitals, but more patients were being referred for admission and had thus crowded the facilities.

And why are there increased referrals to the hospitals? One reason is that the general practitioner is run ragged by people with minor complaints, requests for certificates, prescription refills, and permits. When a really sick person turns up, the doctor is so pressed for time that he often follows the simplest course and passes the patient along to the hospital, perhaps without even a tentative diagnosis.

A specialist at London's famous St. Bartholomew's Hospital told me, "Many people are coming to our out-patient department who, under the old system, would have and should have been handled by a general practitioner. And often we get only two or three lines from the family doctor on the patient's referral slip, or just the phrase, 'Please see'."

A similar clogging of the medical machinery would almost certainly occur in this country if the Government made medical services freely available to everybody, without any brake on those who might be inclined to abuse or overuse it.

Both Mr. Bevan in England and Mr. Ewing in the United States view the increased demand occasioned by a state medical service as proof of its need. Mr. Ewing has claimed that compulsory health insurance would bring "unrecognized, hidden or neglected illness out into the open by making medical care more easily available." But the average doctor in England today has little opportunity to look for the hidden illness or identify the vague symptom. Lord Horder, physician to the King of England and leader of an organized opposition to the health scheme, points out that "the essence of good doctoring is diagnosis, and diagnosis calls for time and a close-up with the patient, both of which are denied to thousands of practitioners here." He says the doctors' time has been spread so thin that the standard of medicine in his country is falling.

What about the cost of compulsary health insurance? When Mr. Ewing predicts that the expenditures for this vast program "would represent new burdens on the economy or the contributors only to a limited extent," he would seem to be either kidding the public or using an unlimited definition of "limited." Judging by the experience of Britain and other countries, government medicine not only costs far more than private medicine but becomes increasingly more expensive as time goes on and the package gets bigger.

The administration spokesmen for compulsory insurance usually dwell on the wage deduction as its main means of support. This would be a 3 percent tax—divided equally between employee and employer—on wages and salaries up to $4,800, an addition to the present 2 percent social-security tax for old-age and survivors' insurance. The self-employed would chip in the full 3 percent. But the administration bill itself would tap the Treasury for a lot more. It would permit a direct appropriation equivalent to 1 percent of aggregate wages under $4,800 to set up a reserve fund. It would authorize another sum to cover the cost of dental services and home nursing, plus "any further sums required to meet expenditures to carry out this title." In other words, the funnel is wide open at the top. American Medical Association critics estimate the compulsory-insurance program would cost 10 or 15 billion a year, or 2 to 3 times what the country is presently paying for medical care.

Even if we are willing to pay for so grandiose a medical program, it would be impossible, or at least extremely difficult, to provide more medical care with the present number of doctors—about 170,000 active physicians. The Truman-Ewing intention is to allow a 3-year "tooling-up" period before putting the scheme into operation, and during this time to start increasing the doctor supply—aiming at a 50 percent gain by 1960—through Federal aid to medical schools and students. In their desire to expand medical education they have support from nearly all groups. But if Government health insurance is in the offing, will it be possible to recruit the high-caliber young men that the profession needs?

In England as well as in America the medical profession has objected to focusing authority in a government officer who may have had no previous experience in medical or health matters. Both the British act and the Murray-Dingell bill set up regional or local boards to deal directly with the doctors, and there is medical representation on these boards. But major decisions are made at the top. In Britain, the Minister of Health, Aneurin Bevan, whose background is labor disputes and not medicine, exerts tremendous power through appointments and the authority to make regulations. He is also the court of final appeal when dismissal of a doctor is sought for "inefficiency" or other reasons—a clause of the act which the physicians fought bitterly, but vainly.

Commander in chief of the Government medical system outlined by the new Wagner-Murray-Dingell bill would be the Federal Security Administrator, currently Oscar R. Ewing, a lawyer and the principal Government salesman of the compulsory-insurance idea. The bill sets up a National Health Insurance Board of five members. But it states that all functions of the board "shall be administered by the board *under the direction and supervision* of the Federal Security Administrator." [Italics ours.] The functions include the making of "all regulations and standards specifically authorized" by the bill "and such other regulations not inconsistent with this title as may be necessary." In other words, the Federal Security Administrator would be the boss, with sweeping powers to regulate and control.

In making regulations, the Federal Security Administrator could consult with a National Advisory Medical Council of 16 members. But the name is somewhat misleading, as only 6 of the 16 must be "individuals who are outstanding in the medical or other professions concerned with the provision of services." And all 16 would be appointed by the Administrator, an arrangement which could permit the council to become nothing more than a rubber stamp for the Administration's decisions. Furthermore, the chairman of the main National Health Insurance Board would serve as chairman ex officio of the Advisory Council.

Each State would develop its own plan of operation, to be carried out under a new or an existing State agency, such as a department of health or welfare. The State agency would make agreements with individual medical and dental practitioners, with hospitals or with voluntary-health-insurance groups, to supply medical and hospital service. The State would be divided into local health areas, each with an administrative officer or committee appointed by the State agency. Doctors and dentists in each local area would be given their choice, to be decided by a majority vote, of three methods of payment: (1) a fee for service based on a fee schedule, (2) a per capita basis—an annual sum for each patient on the doctor's list, as under the English system for general practitioners—or (3) whole or part-time salary. The bill also stipulates that in setting the rates of payment 'consideration shall be given to degree of specialization and to the skill, experience and responsibility involved in rendering the service." This is, of course, only a statement of aims, and to work out a scheme that would recognize variations in skill and experience would be one of the most difficult tasks of the entire program, as the British have discovered.

This organization chart may look neat and simple on paper. But it is the framework for a huge, sprawling pyramid of administrative officials and committees, mainly nonmedical people, who will number in the thousands. And it is this potential bureaucracy—vulnerable to political pressure and characterized by billions of forms to fill out and file, as under OPA—which the opponents of compulsory health insurance see as a threat to the independence and initiative of the physician and to the quality of medical care.

While one cannot judge the whole British system by the creaks and squawks from scattered sections of it, there are certainly many reports of friction between the doctors and the lay boards, some of whose members are unfamiliar with and even antagonistic toward the physicians' problems. I was told of a regional hospital board in Yorkshire which, in staffing hospitals, selected as a surgeon a man who had never done any surgery, and which didn't even have on its lists the name of one of the most experienced men in the community. In fairness to the board, it must be reported that it finally yielded to the organized protests of the doctors of the community and permitted them, in effect, to choose the staffs.

Not all boards have been as reasonable. One lay member, when informed that the doctors' authority on management matters extended only to making reccomendations, replied with some vigor, "That's fine. Then we can veto them."

In the long battle against the rise of socialized medicine in this country, the burden of defense has been carried by the American Medical Association and its fast-talking editor, Dr. Morris Fishbein, who has a beat-'em-down technique in debate. In spite of Dr. Fishbein's dynamic delivery, the AMA has often defended the status quo instead of actively seeking an alternative solution. The organization has in the past opposed or given a cool reception to almost every development designed to solve the problem of the distribution and cost of medical care, including many which have turned out to be beneficial. Hospital- and medical-care insurance plans struggled through their early growth without the benefit of the AMA blessing. Group practice, in which a partnership or team of general practitioners and specialists provide complete medical care, was not given general encouragement, on the ground that some groups were tainted with commercialism.

Much of this conservatism in medical economics is understandable in a profession which must safeguard the public from premature and immature "cures," and which must handle new treatments and drugs with caution until they have been proven safe and effective. But it has often worked to the profession's disadvantage. Plain-spoken Dr. Paul R. Hawley, who overhauled the Veterans' Administration medical department a few years ago and who now heads the Blue Cross-Blue Shield Commission, summed up the reaction of more liberal physicians to this static defense in a recent speech: "I am afraid that a large part of the public has come to expect organized medicine to oppose every suggestion tending to solve this problem of the cost of medical care."

Now, however, organized medicine is at last definitely pushing voluntary health insurance as the best defense against the compulsory Government-directed variety and as an answer to a real need. In a refreshingly frank editorial, the Journal of the American Medical Association recently stated: "No one asserts or claims that leadership in American medicine has not on occasion made mistakes. * * * No one claims even that the house of delegates (representative governing body of the AMA) has not on occasion been slow to change its point of view. But medical leadership does claim that physicians must have evidence of the desirability of new methods and new technics in the delivery of medical service before it can act for the medical profession of the Nation in accepting any proposal. Indeed, the great hazard of such legislation as that which perpetrated the National Health Act on the people of Great Britain is the difficulty of eliminating such a procedure even after its faults have become horribly obvious."

To carry its arguments to the entire population, through speeches, posters, movies and millions of pamphlets, the AMA is now raising a "war chest" of about $3,500,000 through a $25-per-member assessment. (There are 140,000 members.) The AMA's new "battle plan," prepared with the help of its newly retained Chicago public-relations consultants, Clem Whitaker and Miss Leone Baxter, urges organized medicine to "get off the defensive" and to "conduct an affirmative program of education," including "active cooperation with the prepaid medical and hospital plans and the accident- and health-insurance companies, in an all-out drive to provide the American people with voluntary health-insurance coverage."

Most of the AMA's State societies, during the past several years, have established their own prepayment-medical-care programs. These Blue Shield plans, as they are called, are now operating in 42 States and the District of Columbia, and cover a total of about 10,000,000 subscribers and dependents. Annual premiums range from $25 to $50 per family, and the plans pay for surgical and often for medical care, in cases requiring hospitalization. They are usually sold by the Blue Cross hospital-insurance organizations, which now have a total enrollment of about 31,000,000.

Advocates of compulsory health insurance object that the voluntary surgical and medical insurance plans cover only the hospitalized cases and do not pay for home and office calls. This is true in most plans. But medical bills incurred during hospital illness make up half the Nation's outlay for medical care and, for most families, it is the tough half because it comes unexpectedly and in big chunks. It is these big bills which wreck the family budget, but it is the oft-repeated small bills for office and home calls which can wreck either voluntary or compulsory insurance schemes. The reason for this is that when payment of a fixed annual fee entitles people to call the doctor as many times as they wish, the system is abused. The insurance company, paying the doctor for each visit, finds its funds drawn on too heavily. The home and office calls, without restriction on number, are not, in other words, a predictable and, therefore, an insurable risk. The Michigan Medical Service, one of the first State-society plans, started to cover these calls under its annual premium, but almost went broke and had to write in restrictions.

A second important objection to voluntary health insurance is that the poorer people cannot afford the premiums and therefore are not covered. Dr. Gilson Colby Engel, a Philadelphia surgeon and president of the Medical Society of Pennsylvania, recently proposed a plan which would correct this deficiency and which has now become a key feature of the bill introduced by Senator Lister Hill, Democrat, of Alabama. Membership cards in voluntary hospital and health-insurance organizations would be issued to those certified by local welfare authorities as requiring financial assistance. The cards would be identical with those carried by full-paying subscribers, and this would avoid the embarrassment of the "means test" at the hospital at the time the individual was admitted. Federal and State funds would then be used to reimburse the voluntary health-insurance organizations for the bills incurred during the hospitalized illness. At the suggestion of Dr. Paul Magnuson, chief medical director of the Veterans' Administration, the Hill bill would provide diagnostic centers to serve the entire population, again through voluntary-insurance organizations and with State and Federal financial support.

Senator Lister Hill, author of the measure, has long been interested in medical affairs. He is named after the famous English surgeon, Lord Lister, with whom his father, the late Dr. Luther L. Hill, of Montgomery, Ala., studied as a young man. Senators Hill and Harold Burton, of Ohio (now a Supreme Court justice), sponsored the Hill-Burton Hospital Survey and Construction Act, to provide Federal grants for hospitals throughout the country. More than 700 projects have been approved. Hill's four cosponsors on the present health bill are Senators George D. Aiken, of Vermont, Garrett L. Withers, of Kentucky, Wayne Morse, of Oregon, and Herbert R. O'Conor, of Maryland. All but Mr. O'Conor are members of the Senate Committee on Labor and Public Welfare, which will consider this bill, the administration measure and the new health bill introduced by Senator Robert Taft. The Taft bill would establish a National Health Agency to be headed by a doctor and to take in the Public Health Service, the Food and Drug Administration and other health functions now performed by Ewing's Federal Security Administration. It would also makes grants to the States for assisting in the payment of medical-care costs for those unable to pay their own, in a manner somewhat similar to that proposed in the Hill bill. Taft's cosponsors are Senators H. Alexander Smith, of New Jersey, and Forrest C. Donnell, of Misouri. All three are on the Labor and Public Welfare Committee, 7 of whose 13 members are thus sponsoring voluntary rather than compulsory health insurance measures.

This, then, is where we stand today. The lines are more sharply drawn than ever before. Politically powerful groups in the administration and in Congress are determined to push Government medicine through. An equally determined medical profession, without whose cooperation any plan would be sure to strike heavy going, plus millions of laymen opposed to the idea of the hand-out state, are on the opposite side. You are being asked to decide whether you want Government-directed medical care, paid for by compulsory contributions and by taxes, or whether you will reject it as a glittering package that will dilute the quality of medical care, stifle the doctor's initiative, and nick your purse for unpredictably large amounts. Your decision, in the light of the experiences in Britain and other countries, will profoundly affect your welfare for years to come.

(Subsequently Senator Murray submitted the following personal comments and other material for inclusion in the record:)

(By Senator Murray)

I should like the record to show that the editors of Colliers, another publication reflecting pretty fairly many of the views of the American people, agree with the sponsors of national health insurance in many important respects. They feel, as we do, that socialized medicine is not the answer and that as Americans we can work out an American plan of meeting our needs.

COLLIER'S BELIEVES GOOD MEDICINE DOESN'T MEAN SOCIALISM

How would you like to have your doctoring taken care of by the Government? It could happen here. It has happened in Great Britain. Lester Velie of our staff gives his reportorial impression of the first 6 months' experience of the British plan in this week's issue.

In Britain, doctors, medicines, dental care, hospital beds are free. The Government collects the taxes assessed for health and pays the bills. Ninety-five percent of the people look to the Government for their medical care. About the same proportion of doctors and dentists are on the Government panels.

Those to whom Mr. Velie talked like the British service. Patients appeared to approve. Doctors had reservations. The British Government will spend about a billion dollars a year for medical care. Obviously this is a heavy load.

Government medical service could come to the United States in two ways. Gov. Earl Warren is urging the California Legislature to establish a State system of health insurance. President Truman has recommended a national system.

Republicans and Democrats both urge Government health insurance. Of course most American doctors and dentists are opposed to it. The doctors say "No," regardless of whether the plan is State or National. They accept privately operated health insurance. They oppose the Government-operated plans.

The arguments for Government medical care are much the same whether they are being offered by Democrats in Washington or Republicans in Sacramento or Welshmen in London. The gist is that only the well-to-do can afford to pay the high cost of adequate medical care.

In Washington, Oscar Ewing is leading the fight for President Truman's national plan. Mr. Ewing is a Democrat, but he used to be a law partner of the late Chief Justice Charles Evans Hughes. Mr. Hughes was both Republican and conservative. When his partner, Mr. Ewing, sponsors national health insurance in the United States, obviously the proposal will be vigorously presented.

As the arguments about Government doctors and private doctors reach Congress, the newspaper headlines and the radio broadcasters, it will not accordingly be easy to brush it off as a Socialist scheme. Oscar Ewing is much too adroit a counselor to let his client, President Truman, be put in that hole.

Free medical care, however, is a Socialist project in Great Britain. The Labor government is a Socialist government. The British now like the word Socialist. After 1950, when there will be an election, they may think differently. Or, maybe not.

Oscar Ewing in Washington says national insurance is simply a method of paying for complete medical care by a prepayment plan. If his program is adopted he thinks that through the Social Security Agency 85,000,000 Americans will be immediately cared for by the national health insurance plan. Later the plan will be extended to take care of 120,000,000 to 130,000,000 people.

Mr. Ewing argues that half of us live in families in which the income is no more than $3,000 a year. Such people, he says, cannot afford and do not get adequate medical care. Mr. Ewing says that only 20 percent of our population can afford to take full advantage of the benefits the present system offers.

The doctors generally—with exceptions, of course—and the American Medical Association in particular disagree wholly with the Ewing plan. They do not concede his facts. The administration in spite of opposition is pushng for natonal health insurance.

Socialist or otherwise, so far as our reporter learned, the British patronize and approve their national health plan. It is true that in Britain patients have to stand in line to get to a doctor's office or to a dentist's chair. Patients have to see doctors listed by the Government. Doctors in the plan may not charge fees to Government patients. They can, however, have private patients.

But the majority of the British seem to be getting something better than they had before. So far as the record goes both patients and doctors like the new plan. There is a minority who do not like Government medicine. Perhaps 16 percent of the doctors are not in the plan. The question will come up in 1950 when the new election is held.

Collier's thinks that American doctors and American political leaders should give open-minded consideration both to the British experience and to the American needs. Are Oscar Ewing's figures right? Do a majority of Americans fail to get adequate medical care?

A great many Americans admittedly do not have adequate medical and dental care. A very great many who do have competent care pay much more than they can afford. For a man of middle income a serious illness can be a major financial catastrophe.

Much progress has been made lately in developing private insurance plans for paying for both medical and hospital care. Collier's thinks that both sides to the argument in this country should make concessions.

If the doctors and the politicians are willing to look at the facts, there should be no trouble in working out an American plan. We don't want to be socialistic. We do want good medical care. We do want to be finacially solvent and independent. Why not start out with good will all around to work out a distinctly American answer to a great human problem?—W. L. C.

(By Senator Murray)

Since the opponents of national health insurance havbe made so much to do about the increased cost of the British health service system, I should like the record to contain some responsible British source of information on the factors involved. The following article entitled "The Cost of Health" accounts for the major costs of the British health service system and makes it quite clear that "abuse" of the system is not a relevant factor.

[From the News Statesman and Nation. January 1, 1949]

The Cost of Health

The cost of the National Health Service will be much in excess of the estimates. By the end of the financial year (9 months' working of the Service) the cost. instead of being £180,000.000, will be over £225,000,000—an excess of over £1,000,000 a week. We doubt whether the Minister of Health will be much embarrassed by this figures: they are, in fact, both a measure of the success of the National Service and a revelation of the urgent need for it.

The irony is that the very violence of the B. M. A.'s opposition so well advertised the Service and increased its popularity (and its consequent expense) that by "vesting day," July 5, nine out of ten people had registered. Today, over 97 percent of the 21,000 general practitioners and over 87 percent of the 10,000 dentists in England and Wales, and, in Scotland, 2,339 out of 2,386 G. P.'s and 1,000 out of 1,200 dentists, have joined the Service. The hospitals, which were taken over, have cooperated so energetically that their activities will account for at least 60 percent of the rise in costs.

The public, including the middle class and the well-to-do, are taking full advantage of the scheme, while the doctors, though individuals grumble over details, are, as a profession, cooperating magnificently. Of course, there are instances of offhand treatment and scamped work. Such cases attract attention, but they are rare indeed compared with the loyal service, under great difficulties, of the overwhelming majority of the doctors. There have been abuses of the Service by both doctors and patients, but, again, while loudly canvassed, they are a split fraction of total practice. For instance, there has been a great deal of talk about overprescribing—stout and whisky and expensive and unnecessary drugs—but of 75,000,000 prescriptions dispensed so far only 1,000 prescriptions have been queried. Again, there have been complaints from doctors that patients are coming to them for prescriptions for free aspirins and purgatives; but, while it may be an excessive demand on busy practitioners and an avoidable charge of the public funds, the doctors have no professional right to resent it. They have been complaining of "self-medication" for years and here, in the long run, is the chance to curb it and substitute proper treatment. The run on the chemists is certainly higher than was anticipated. Instead of the budgeted 2,700,000 prescriptions a week, they are averaging 3,000,000. This increase is substantial but by no means alarmingly high in proportion to the total cost of the scheme.

Some may say that the cost of the dental service has already assumed the proportions of a public scandal. There is no doubt that the trial-scales of payment were excessive and the Minister has taken steps to correct that. But what does emerge is the shocking neglect of the nation's teeth in the past. Allowing for the shortage of dentists (and it would need three times as many to take up the present slack), the scheme could not pretend to cope with these arrears; the only possible plan was to restrict dental plates to essential cases and lay emphasis on conservation of teeth. The worst aspect of the change so far has been that the teeth of children and expectant mothers (the care of which is the best investment for the future) may be neglected through the desertion of clinic dentists to lucrative surgeries. The experience of the first months does indeed raise the question whether itemised scales and private surgeries can be long justified either in terms of finance or dental efficiency. When a dentist nets £6,000 a year, as some are doing, it can only be through scamped work, or over work—which amounts to the same thing. Public interest and well-being may compel, what Mr. Bevan has not suggested, a salaried dental service and public dental clinics.

Another surcharge on the scheme has been the rush for spectacles and opthalmic examinations. It was estimated that 4,000,000 pairs of spectacles would be needed in the first year; the rate is now running at 7,000,000 a year; the sources of supply are overburdened and delays are lengthening; the corresponding costs for examination have risen. The factors are fairly obvious and might have been foreseen with more accuracy.

Among old people surveys have shown that out of 6,000,000 at least 5,250,000 wear spectacles for reading; of those, a million have never had their sight tested (their glasses came from the self-test counters of the multiple stores) and 2,000,000 have not had their sight tested for over five years. They have taken the chance of getting suitable spectacles. And, perhaps, one of the merits of the spectacle scheme has reacted to its disadvantage. There has been an insistence on variety in the frames; there are twenty different styles, of which eleven are free and the other nine can be had for an extra charge ranging from 1/- to 8/-. People who might have been discouraged by strictly utilitarian models (and the "standardised owl" that the critics predicted) have found the cosmetic as well as the opthalmic effects attractive. But the rush will find its own level and the State investment in improved eyesight will be more evenly spread over the years.

Another big item is surgical appliances, issued through the hospital services, artificial limbs, hearing aids, surgical boots, and so on. These are costly, and the demand has been more than predicted but not, obviously, more than the need. These appliances are issued only where the medical profession is absolutely satisfied that the patient's health and physical efficiency requires them. What it means is that thousands, who have been suffering in silence from impaired health and disability, are now being rehabilitated. As a jester remarked this may be putting the Service "in the red," but it is putting the nation "in the pink."

By far and away the heaviest load is the hospital services, even without the large rebuilding programme which has been suspended under the ban on capital works. The hospitals boards are energetically providing essential equipment which most of the voluntary hospitals could not afford. The Whitley Council has awarded the student nurses over £2,000,000 more a year and £1,500,000 more for hospital domestics. No one can grudge that or, if they do, they will have to find alternative inducements to attract and keep people in a profession so long underprivileged. The Spens Report on hospital consultants and medical staffs did not appear until after the initiation of the scheme. The results are just beginning to show. They entail a heavier salary budget than was estimated.

The scheme is in its infancy; the sickness services of this country have revealed deficiencies too long concealed; the costs are heavy, but the ultimate dividend is incalculably high.

NATIONAL HEALTH PLAN RATES HIGH WITH BRITAIN'S VOTERS—PROGRAM FAR MORE POPULAR THAN ANY OTHER LABOR GOVERNMENT MEASURE, SURVEY SHOWS

(By George Gallup, director, American Institute of Public Opinion)

PRINCETON, N. J., December 17.—The powerful political appeal of national health insurance, a program which President Truman has repeatedly urged Congress to adopt, is evident in one nation which recently put such a program into effect—Britain.

British voters in a nation-wide survey have voted the national health scheme the best thing which the Attlee government has done since coming to office more than 3 years ago. It far outranked any other measure in popularity.

The British program went into effect July 1, just about the time when Democratic Party leaders were preparing the 1948 Democratic platform, which pledged a national health program for "adequate medical care." President Truman reiterated his support of the idea in many campaign speeches and Washington observers believe that it may be one of the President's "pet measures" for action in the Eighty-first Congress.

The British survey was conducted by the British Institute of Public Opinion which forecast the election of the Labor government in 1945 with an error of only 1 percentage point.

BRITISH POLL

"What would you say is the best thing this Government has done since it came to office in 1945?"

	Percent
National health scheme	35
Increased pensions, looked after old people	12
Nationalization of industry	7
Kept rationing, kept food prices down	4
Wage increases, holidays with pay	4
School meals, raising school leaving age	2
Improved housing	2
Prevented unemployment	2
Stood firm against Russia	1
Miscellaneous and no answer	21
Done nothing good	10

When the British health program went into effect, Britishers flocked to doctors, dentists, clinics, and hospitals by the scores of thousands to take advantage of the free medical services provided under the plan.

In fact, more than a third of the adult population used the services of the plan during its first 3 months of operation, according to another survey by the British institute. More women were treated than men.

In October the British Institute asked voters:

"Have you had occasion to use any of the services of the National Health Scheme during its first 3 months of operation?"

The results:

		Yes	*No*
National	percent	38	62
Men	do	33	67
Women	do	43	57

The vast majority of those treated said they were satisfied with the care they got, and had no criticism.

"Were you satisfied with the treatment that you received or did you have any criticism?"

	Percent
Satisfied	35
Dissatisfied	3
Total treated	38

In this country a number of proposals for national health legislation have been considered in the past 2 or 3 years. Extensive hearings were held last year on a proposed National Health Insurance and Public Health Act, sponsored by Senator James E. Murray, Democrat, of Montana, and other Senators.

Under this bill people covered by the insurance would receive preventive, diagnostic and curative services by their family physicians, with the service of specialists as required. They would also receive hospital care, laboratory and X-ray services, unusually expensive medicines and special appliances. Dental care and home nursing would be provided to a limited degree.

Employees would pay 1½ percent of their earnings up to $3,600 and their employers would contribute a like sum. If self-employed, the person would pay the entire 3 percent up to $3,600 of his earnings.

[From the Trade Union Courier, June 20, 1949]

"Call the Doctor"

(By Louise Morgan)

> The author, Louise Morgan, is on the staff of the London "News Chronicle" and is an expert on social questions. After personally visiting families on different levels of British society, she wrote this account of Britain's new National Health Service which came into operation in July of last year.

I have just spent a day in a dockside district in London, where there is an average of three children to a family. Most of the fathers are stevedores earning about $25 a week. Typical of the district is the Brown family. The youngest child is 2-year-old Colin, whose picture would make a superb advertisement for baby food.

"Colin is doing so much better than my other babies," said Mrs. Brown, as she put the kettle on, and we settled down comfortably by the kitchen fire. "The minute he started sniffling I wrapped him up well and took him to the doctor. I believe it saved him months of suffering from bronchitis. My others had it regular. I used to worry whether I dared call the doctor or not. Now we can have him when we need him."

It was while the doctor was attending Colin that he suggested that Mr. Brown should have his eyes tested. For years Mr. Brown had been wearing glasses handed on to him by his father, innocently believing that what was good enough for his father was good enough for him. The doctor made an appointment for him with an ophthalmic optician, and he now possesses two pairs—one for general use and one for reading—and the headaches which used to keep him away from work have nearly disappeared.

The doctor sent Mr. Brown to another specialist, as he suffered from indigestion, and he was given a thorough medical examination for the first time in his life. The specialist prescribed special exercises and a diet for him.

"I honestly believe his life was saved by the specialists," said Mrs. Brown. "As for me, I'm having the new set of teeth I've dreamed about for years. I had all my teeth out 10 years ago when I was 26, and I've never been to a dentist since. I thought I was going to be toothless for the rest of my life."

I heard the "Brown story" in every house on the little street, and before evening I had toasted the new service in many cups of tea.

Next day, I knocked on doors on a suburban road where the families of lawyers, teachers, and other profesional men live, and found that since the end of World War II, high cost has been just as great a deterrent to the obtaining of proper medical treatment as in the poorer dockside district. The wife of a bank official earning $4,000 a year told me that the bills for the 2-month illness in 1947 amounted to a quarter of their annual income. She still needs expensive medicines, but now through the new service gets these free. She said "the first time I got my prescription filled without charge I simply couldn't believe it. It's hard to believe, after you have been spending so much on illness to find there are no more doctor's bills.

All the prophecies that the national health service would not work have proved false. Men and women of all incomes, and practitioners in every branch have flocked into it. The figures of those who have already joined it are amazing: 41,500,000 people, or 93 percent of the entire population; 18165 doctors out of about 21,000; 9,194 dentists out of about 10,000; and practically all pharmacists.

Just as remarkable are the figures which reveal how badly the health service was needed. The number of sight tests in the first 7 months was over 2,500,000, and the number of pairs of eyeglasses supplied over 3,000,000. The number of pairs of glasses which will be applied for each year is estimated at 8,000,000.

The figures of applications for dental treatment—3,400,000 in the first 7 months, 40 percent of which were for dentures—reveal what a great need there was for dental treatment and for dentures.

The deaf are to obtain free the finest possible hearing aids. By the end of January 1949 diagnostic clinics for hearing aids had been established in 89 hospitals, and 22,407 of the new aids had been received from the suppliers. The estimated number of these needed is 150,000.

The London County Council's first comprehensive health center, to be built on the bank of the New River in North London at a cost of 187,000 pounds ($750,000), will serve 20,000 people and will contain six complete doctors' suites and six dentists' suites as well as a child welfare clinic, school-treatment clinic, child guidance unit, ante- and post-natal clinic, and a nursery school. Here—with every modern facility such as laboratories, X-ray, recovery rooms, dressing rooms, restaurant, and furnished apartment for the doctor who is on night duty—general practitioners will for the first time be able to interview, examine, and diagnose their patients in almost ideal conditions.

As soon as materials and labor become available, other health centers will be set up in every part of Britain. Not only will the sick be healed, but citizens will also be taught how to keep healthy. It is hoped that with the emphasis on building up health, and keeping it, many of the ills that plague us will be wiped out within a generation.

(By Senator Murray)

While there are many points on which we may make valid comparisons between the British health service system and the national health insurance program proposed in this country, I think we need to bear in mind points of difference as well. As I see it, here are six major points of difference between the British plan and our American proposal for health insurance.

Points of Difference Between British Plan and American Proposal

(1) *Financing.*—In Great Britain, most of the costs are being met through general taxes with only a small proportion of the funds consisting of contributions from the insured. We propose just the reverse.

(2) *Ownership of hospitals.*—In Great Britain, most of the hospitals have been taken over and are now owned and operated by the Government. Under our plan, hospitals would retain their independent and private status, they would be free to participate or not as they chose, under the program.

(3) *Reimbursement to doctors.*—Whereas under both plans doctors have a choice of how they wish to be paid, we propose a choice between fee for service, capitation, or salary. The British offer a choice between capitation or a combination of capitation and salary.

(4) *Location of physicians.*—Under the British system the Government exercises some control over the location of a physician's practice. We propose to work out the problem of distribution of personnel on the basis of incentives rather than coercion (e. g. minimum income guaranties, provision of facilities, aid for transportation costs, etc.).

(5) *Furnishing of drugs.*—Whereas the British system furnishes all drugs prescribed by physicians, under our plan only unusually expensive medicines and drugs will be provided as insurance benefits.

(6) *Administration—State rights.*—While England is a relatively small country, we are a tremendous country and traditionally operate through 48 States

and 48 State legislatures. This obviously suggests that we may have a pattern of administration that is more diversified than the British.

Senator DONNELL. The next witness is Dr. Joseph M. Babcock, who is here representing the American Optometric Association.

STATEMENT OF DR. JOSEPH M. BABCOCK, VICE PRESIDENT, AMERICAN OPTOMETRIC ASSOCIATION

Senator DONNELL. Doctor, have a seat and state for the record your name and the organization you represent here today.

Dr. BABCOCK. My name is Joseph M. Babcock, and I reside at Portsmouth, Ohio. I am and for 7 years have been vice president of the American Optometric Association and director of the department of national affairs of this association.

Senator DONNELL. Doctor, does your organization have a house of delegates similar to the American Medical Association?

Dr. BABCOCK. They do.

Senator DONNELL. Do you consider the house of delegates of your organization as being representative of the views of the members of the organization?

Dr. BABCOCK. Yes.

Senator DONNELL. You do not belong to the American Medical Association?

Dr. BABCOCK. No, sir.

Senator DONNELL. Have you observed the work of the house of delegates of the American Medical Association?

Dr. BABCOCK. Yes.

Senator DONNELL. Would you tell us, please, whether or not in your opinion the house of delegates of the American Medical Association represents fairly and generally the views of the members throughout the United States of the American Medical Association?

Dr. BABCOCK. If it is similar to ours, I would say they do.

Senator DONNELL. All right, sir, thank you.

Now, go ahead, Doctor.

Dr. BABCOCK. I am a practicing optometrist. I am also secretary of the Ohio Optometric Association, having held this office for 11 years.

The American Optometric Association is the national organization representing the profession of optometry. It is constituted in the same manner as are similar organizations representing other health professions. The individual optometrist joins his local association, or in a few of the smaller States, where there are no local organizations, he joins the State association directly.

In the larger States, there are county, district, or zone groups. Upon joining the local organization, the optometrist automatically becomes a member of his State and national association and so, likewise, when he becomes a member of his State association, he automatically becomes a member of the national.

A recent survey indicates that there are about 18,000 optometrists licensed and registered in the 48 States and the District of Columbia. Excluding duplications and the like, approximately 15,000 are actively engaged in practice. There are probably more than this number, because during the past several years a substantial number of veterans have returned to interrupted optometry courses and have been graduated and licensed.

The educational qualifications will be discussed more in detail by Dr. H. Ward Ewalt, who desires to present his testimony after mine. Suffice it to say that graduation from one of the schools or colleges of optometry giving at least a 4-year course is a prerequisite to taking the licensing examination in every jurisdiction. Just as in the case of medicine, dentistry, and other health professions, the statutes of all of the States provide for boards of examiners in optometry, which boards have assigned to them the functions of licensing and regulating the practitioners of optometry.

Optometrists are the only persons in the field of health who are specifically and exclusively trained and especially examined and licensed to care for human vision.

There are two other groups which care for vision. One of these groups is composed of ophthalmologists. An ophthalmologist is a physician who has specialized on the eye and who has taken and passed an examination given by the American Board of Ophthalmology. There are only approximately 2,600 of this group diplomated in the United States. Ophthalmologists confine their practice exclusively to the eye and the great majority of their time is devoted to the treatment of diseases and surgery of that organ. In the opinion of most ophthalmologists refraction or the analysis of vision and the prescribing of corrective lenses, visual training, or both, are only an incidental part of the practice of ophthalmology.

The other group is known as the oculist. The oculist generally does not confine his practice to the eye but extends it to cover the ear, nose, and throat. Thus only a small fraction of their time is devoted to the eye. There are approximately 7,000 of these so-called eye, ear, nose, and throat specialists in the country.

Seven out of ten persons who require visual care voluntarily seek the services of optometrists, becoming and remaining their patients. The other three are patients of either the ophthalmologist or the oculist. Eminent ophthalmologists have stated in their writings that the percentage ranges even higher to between 75 percent and 80 percent, but we are content to take the lower figure.

The only other place we find optometry mentioned in these bills is in title VII of S. 1679 under the heading of "Auxiliary services."

We earnestly contend that the care of vision is not an incidental or secondary phase of health care and it should not be grouped with auxiliary services. The care of vision should be a primary and independent function. This is not a question of professional pride but of the welfare of our patients and of the cost to the taxpayers.

This statement relates primarily to S. 1679, but further on the other bills are specifically discussed. All are in need of amendment in the interest of improving and conserving the vision of the American people.

From time to time national health conferences are held in this city at the call of the President and lengthy, statistical reports are made.

May I quote but one sentence from this maze of figures:

> Thirty percent of all children under 15 years of age have defective vision due to refractive errors.

The best commentary to this is the statement of a school superintendent, reported at one of these conferences who said:

> To give a child a book to read and then not provide him with such aid to nature's gifts that will enable him to read it, cannot be called a judicious procedure.

Studies have been made by the American Medical Association, the National Educational Association, the Milbank Memorial Fund and other groups all of which show that defects in children's vision range from 20 percent to 26 percent.

Childhood is the formative and crucial period of life. We dare not afford to gamble with the health of our children upon which the very foundation of the republic stands.

As the children advance they become high school and college students or they go into agriculture, business, or industry.

As the child continues his studies, the percentages of those having defective vision rises.

In industry, merely by way of example, the United States Public Health Service made a number of studies and found that the percentage of defective vision ranges from 15 percent to 20 percent in the cement, foundry, cigar, and pottery industries, to 40 percent to 60 percent in post offices, gas, chemical, and garment industries.

Senator DONNELL. Doctor, might I interrupt you there?

Is it your meaning that in the cement, foundry, cigar and pottery industries, persons engaged who have defective vision number from 15 to 20 percent of all those engaged in those industries, respectively?

Dr. BABCOCK. Yes, sir.

Senator DONNELL. And in the case of post offices, gas, chemical, and garment industries, from 40 to 60 percent of all those persons engaged in those particular occupations have defective vision?

Dr. BABCOCK. That is right.

Senator DONNELL. You are not indicating the extent of defect, but they do have some defective vision.

Dr. BABCOCK. That is right. The different industries call for different tests on their work—on their eyes.

Senator DONNELL. Yes?

Dr. BABCOCK. That is correct.

A person in industry who cannot see clearly, comfortably, and efficiently is a menace to himself and to his coworkers as well as a liability to his employer.

The Milbank Memorial Fund investigation shows that defective vision in rural and agricultural areas ranges from 22 percent in ages 15 to 29 up to 89 percent at the age of 60 or over.

Senator DONNELL. May I stop you again at that point?

You do not mean there, I take it, to be indicating the percentage of defect, but are talking about the percentage of individuals who have defective vision.

Dr. BABCOCK. The need for visual care, the percentage of people who need visual care.

Senator DONNELL. In other words, in rural and agricultural areas, those persons who have defective vision, and I am using your words, range from 22 percent, in ages 15 to 29, and up to 89 percent at the age of 60 or over.

Dr. BABCOCK. They will all need glasses, for reading at the age of 60.

Senator DONNELL. I wanted to get that. These percentages at first sound like they might mean you are talking about the percentage of defective vision, but you are talking about the percentage of individuals that have defective vision in those occupations or in those areas, is that correct?

Dr. BABCOCK. That is right.

Senator DONNELL. Thank you.

Dr. BABCOCK. I need no statistics, though they are available, to prove the cause of many an automobile accident and its resulting fatalities was defective vision.

Public Health Report reprint No. 1404, states that after 50 years of age, the percentage of eye defects vary between 70 percent and 80 percent among professional, business, labor, and agricultural groups.

Leaving statistics entirely aside, I respectfully ask the members of the committee to think for a moment how many people they meet daily who use eyeglasses. Let us stop to think for a moment of how the efficiency of the Congress itself would be affected if at a magic word every person connected with the Congress was deprived simultaneously of his visual care and his eyeglasses.

The very vastness of the visual problem in the United States is such that it cannot be a secondary or auxiliary health requirement. There are not only health but social aspects which are equally as important. Without comfortable and efficient vision a happy child can become a juvenile delinquent. An ambitious high school or college student can become a dullard. An enterprising worker through inefficiency of vision loses his productivity, decreases his own earning power and impairs the quality and quantity of his employer's product. A gentle, kindly automobile driver can become a killer in possession of a deadly weapon wrecking havoc among mothers and children, simply because he cannot see well.

Organized medicine is one of the most powerful groups in this country. It exerts influence far beyond its numbers. It tenaciously follows one set policy—namely that anything directly or remotely relating to the human body or human health should be exclusively under the domination and control of medicine. Because medicine deems the care of the eye in itself a small specialized field and because refraction or the analysis and correction of vision is only a fractional part of this already small field, medicine disregards the over-all picture; fails to see or realize the social and economic aspects of good, efficient vision and seeks to relegate the care of vision to a place of secondary importance. Medicine has always failed to realize the importance of good vision.

In 1932 a multivolume report was published on the "Cost of Medical Care." This report was the result of a study of many years by a committee appointed by President Hoover under the chairmanship of the Secretary of the Interior, Dr. Ray Lyman Wilbur, and in this report it is stated:

> The medical profession has objected to the refraction of the eye and the prescription of lenses by optometrists, since physicians considered this new work to come within the jurisdiction of medical practice. Nevertheless, relatively few physicians become oculists, and, of those who did, many were quite poorly qualified. In large degree, the existence of optometry on its present basis is due to the failure of the medical profession to recognize the importance of this field and

> its failure to provide needed services. The training received by medical students does not qualify them to do refraction. The curriculum devotes relatively little time to the eye. Furthermore, until recently, adequate postgraduate facilities for the study of ophthalmology have been lacking.

Which brings us to our second point, S. 1679 by relegating the care of vision and the practice of optometry to a secondary position and by further requiring that auxiliary services, such as optometry, may not be obtained unless the person requiring optometric care first receives a referral from a medical practitioner, wrenches and disrupts the present satisfactory manner in which a person today, with complete freedom of choice may seek the services of his optometrist.

If "freedom of choice of practitioner" really means what it says and is not an idle phrase or empty slogan, then the person in this country who has defective vision should have the right, free and untrammelled, to go to his optometrist for visual care. He does so today. At least seven out of ten are the optometrist's patients. We keep on repeating that figure because if by this or any other bill these 7 out of 10 are diverted to medical practitioners, chaos will result.

I respectfully refer to the figures which I gave at the outset of my testimony: 15,000 practicing optometrists, 2,600 ophthamologists utilize most of their time for pathology and surgery; the oculists have three or four specialties and devote only a fraction of their time to the eye.

Where will the patient who requires visual care go? There are not enough medical practitioners to take care of them. The mere desire on the part of organized medicine to take unto itself the practice of optometry should not, cannot be weighed in the balance against the detriment which such a situation would work upon the public.

Optometry does not desire to be critical of the training, skill, or ability of the medical refractionist. Let us quote from a very recent article appearing in the American Medical Association Journal on November 27, 1948. At page 952 appears an article entitled "Verified Refraction" by Dr. S. Judd Beach, himself a noted and eminent ophthalmologist. From this article and the discussion which followed it, we quote the following:

> This paper is inspired by the limited knowledge of refractions exhibited by the candidates for board examination. Even the candidates who obtain satisfactory results at the practical examinations show training confined to only one of the standard methods. Young assistants can usually operate on cataracts better than they can fit patients with glasses.

That refers to the young practitioner.

> The older ophthalmologist often falls into a rut and, from lack of time and greater interest in the more spectacular aspects of surgery and pathology, fails to "verify" his refraction. The result is that the majority of older ophthalmologists are notably poor refractionists.

That refers to the older practitioners.

Despite these admitted shortcomings, medicine still jealously insists upon controlling and dominating the complete field of health care and from the foregoing, it is apparent that medicine insists upon this monopolistic control despite the detriment which it works upon the public.

The avowed purpose of medicine is to monopolize the health-care field. The optometrist and medical eye men are economic competitors. However, only a very small percentage—between 5 and 8 percent—

of all persons whose eyes are examined have conditions which require medical or surgical attention. The remaining 92 percent or more require complete refractions or visual training to correct their visual deficiencies.

Medicine has always resented optometry and from its inception, nearly 50 years ago, has sought to extinguish it. Having failed to accomplish this, medicine now seeks to relegate optometry to the status of a technician subservient to medicine.

Optometry has filled a need in the health care field which medicine for a time failed to see and has since sadly neglected. As a result, optometry has become over the last half century, an established and important profession. It is an independent profession. By "independent" we mean a person who seeks visual care, may of his own free will, seek out and become the patient of an optometrist without any referral. The patient presently has the right of not only selecting the individual practitioner of his choice, but also the type of practitioner. Because optometry has established an excellent service and has proved its need and usefulness, it has attracted and holds at least 70 percent of the patients. They presently are and should continue to be free to select an optometrist when they want one without the leave or let of a practitioner of another profession.

The whole intent and purpose of the pending National Health Insurance and Public Health Act states and reiterates this American plan of freedom of choice to the patient in selecting the practitioner and freedom of the practitioner in rendering his services. At the very outset in section 3, S. 1679 states:

> * * * that physicians and other professions furnishing services in accordance with the provisions of this act, shall be assured full freedom in the practice of their profession, * * *.

To place the entire profession of optometry in the status of an auxiliary service subservient to medicine is inconsistent with this declaration of policy.

Section 703 of the bill is highly objectionable for this provides that whereas an individual may freely procure general medical or general dental services by applying directly to the practitioner of the individual's choice, he may only receive auxiliary services of which optometry is a part when he is referred to an optometrist either by the physician from whom he is receiving medical care or by an administrative medical officer to whom he must first apply.

Such a provision completely changes the present method of optometric care. Today an individual seeking visual correction needs go to no one in order to be referred to an optometrist. He may and he does follow the first dictates of his own choice and that his own choice has most frequently been upon the optometrist is demonstrated by the seven to three ratio previously mentioned.

This may annoy medicine but we respectfully contend that it is completely contrary to the public interest to attempt to utilize a bill which seeks to broaden and increase health care so as to disrupt and change a practice which has been functioning satisfactorily for 50 years. This bill should not be used as a vehicle to upset an accepted and established method whereby the public can procure visual care by applying in the first instance directly to the optometrist as an independent practitioner without referral.

This bill should not be so worded if it goes to final passage as to give medicine the right to relegate optometrists to the status of technicians. That, too, would be contrary to the public interest. Because of independence of optometry and its freedom from the domination of medicine, the profession has advanced to the point where the vision of the American public receives better care than that of the public in any other part of the world.

Most of the advances in the science of seeing and in the correction of vision have taken place in this country and they have been the result of the work of optometrists, physicists, and other optical specialists who are not medical practitioners. To subjugate a profession which has always been independent since its inception, to the domination of another profession must of necessity stifle it—to the consequent detriment of the public.

More and more frequently in the addresses and writings of prominent physicians are found the veiled statements or threats that ophthalmology can train a lay person in 6 months to do refractions and perform the work of the optometrist. That same suggestion was made before a congressional committee upon the hearing of another bill. It was laughed down then as a result of the testimony of the dean of the graduate schools of Ohio State University and deserves the same treatment today were the implications not so serious. No clear-thinking individual can conceive that a lay person can be taught in 6 months' time to refract, when the course in the optometry schools has been 4 years and beginning this fall is to lengthened to 5 years. If, as a result of this bill, medicine intends to train thousands of technicians and loose them upon the public after 6 months of training, this indeed would be a terrific calamity. The effect of this bill would then be a substantial set-back as far as the care of the public's vision is concerned.

No bill, including S. 1679, should be passed if it will provide a means of reversing the progressive success which the profession of optometry has achieved in caring for the visual needs of the American public and of relegating this group who have accomplished so much for so many to the status of technicians supervised by those who have never appreciated the importance to the health and welfare of our Nation of professional refraction and visual training.

In an effort to advance the health and welfare of the people of this country the Congress will not, I am sure, deliberately take away from millions of patients the fine optometric care they are now receiving and force them to first go to a different type of practitioner or to a public official for a referral.

S. 1581 is likewise deficient or may I say even more so because it makes no reference to visual care or optometry. Its provisions seem designed to apply to matters of procedure and administration rather than to matters of substance. Title II of S. 1581 provides for grants in aid for extending medical, hospital, and dental services to individuals unable to pay the whole cost thereof. There is no provision at all or even reference to optometric services. It is fine to have good teeth, but their owners' economic usefulness is greatly impaired if he cannot see well enough to earn the livelihood sufficient to buy the food upon which to use his teeth.

So, likewise, title III provides for health services for school children and again is completely oblivious to the fact that good vision is synonymous with good school children and learning. To paraphrase the school superintendent whom I mentioned before, what good is it to give a child a book if he cannot see to read it?

S. 1456 is even more deficient in the matter of providing for over-all health care. It merely refers to and provides for hospital and medical care without any reference to vision or optometry.

S. 1106 confines itself exclusively to grants to States for medical aid thereby ignoring the importance of the improvement and conservation of vision to the public.

We do not wish our position to be misunderstood. The three bills which I have just mentioned may have some salutary purposes.

It is not our intention to suggest to the Congress which, if any of these bills, should be enacted into law, but rather to point out that it is indispensable to the public interest that certain amendments be offered by this committee, if, as, and when the bills or any of them are reported to the Senate.

The amendments which we propose would make available to the beneficiaries of the legislation the services of the members of the optometric profession to the same extent and on the same basis as are the services of physicians and dentists. By so doing the cost of the program to the Government would be reduced because obviously taxpayers will have to pay the expense of the so-called referrals, irrespective of whether they are made by a physician or by a medical administrator. The beneficiaries of the legislation would be saved the time and expense involved in securing such referrals, as well as being allowed freedom of choice of the practitioner. The profession and science of optometry in serving the visual needs of our people would be advanced.

The amendments which we believe necessary to accomplish these results are quite numerous and are attached to this statement. It is not my purpose to discuss them specifically, but merely to submit them to the committee as an aid in rewriting such of these bills as the committee decides to report favorably.

Senator MURRAY. Doctor, your principal objection to the bill is that it requires an optometrist to be called only through referral by a doctor.

Dr. BABCOCK. My main objection is that it relegates the profession of optometry to an auxiliary service, which it is not now.

Senator MURRAY. And that would have a very serious effect on your profession, you think?

Dr. BABCOCK. I think it would.

Senator MURRAY. I sympathize with you there, Doctor.

My understanding is that a very high percentage of the care of the eyes now, is performed by optometrists—what is the percentage you give there?

Dr. BABCOCK. Medical men themselves say up to 80 percent. We claim 70 percent.

Senator MURRAY. Pretty nearly every city and town in the United States now have optometrists who are set up and do that business almost exclusively. The distribution of them is most wide. I think that is true because that has been my experience in Butte, where I live. I always go to an optometrist and have gotten the glasses I wear now from an optometrist, who prescribed them for me. I have not had an examination for 2 or 3 years, so I guess I will have to go back and get a check-up; but, 3 years ago I went out here to the hospital at Bethesda and they checked my eyes out there and told me the prescription I had was all right, that it was a perfect vision.

Dr. BABCOCK. Did the physician know that an optometrist had prescribed them?

Senator MURRAY. You say, in one part of your statement that in each State you are required to be licensed?

Dr. BABCOCK. That is right. There is a State board.

Senator MURRAY. And before you can be licensed, they have to go through a very careful examination, they have to follow out a very careful course of studies in school that trains them for this character of work?

Dr. BABCOCK. My son is going 5 years to Ohio State.

Senator MURRAY. You say here in one part of your statement:

> Because optometry has established an excellent service and proved its need and usefulness, it has attracted and held at least 70 percent of the patients. They presently are and should continue to be free to select an optometrist when they want one, without leave of another practice or profession.

That is the system at the present time, that the people can go without asking a doctor, right into an optometrist and have their eyes taken care of; but under this bill, if the language of the bill is retained as it is right now, it would make it possible for the doctors to provide auxiliary assistance and the trained optometrist could be left out of the picture entirely, under this bill?

Dr. BABCOCK. And the public would not be served as well.

Senator MURRAY. You say the bill should not be so worded that in its final passage it would give medicine the right to relegate optometrists to the status of technicians, and I think there is a lot of truth in what you say.

It does seem to me that after having to go through the training of 4 or 5 years and have established a business in this country, and—how many thousands are there in the United States?

Dr. BABCOCK. Fifteen thousand actively engaged in the practice.

Senator MURRAY. I think I can assure you, doctor, that it was not the intent of the sponsors of this bill, when it was originally worded, to undertake to subjugate your profession. We were thinking more in terms of medical and dental care at the time, and I can see how a provision should be made there to protect your profession.

I think the medical men of the country would recognize that themselves. A person comes to a doctor in a town where they don't happen to have an optometrist and he recommends that they go to the optometrist because he does not have the facilities there to properly check their eyes.

Dr. BABCOCK. That is right.

Senator MURRAY. Thank you.

Senator DONNELL. Doctor, I understand from your statement that each of these bills that you have mentioned you think is subject to proper criticism because of the omission of the proper provision with respect to optometrists.

Dr. BABCOCK. Yes, sir, there should be a provision made in them.

Senator DONNELL. I notice on page 3 of your statement, you say:

The only place we find optometry mentioned in these bills is in title VII, S. 1679, under the heading "Auxiliary Services."

Dr. Babcock. That is where the name "Optometrist" appears.

Senator Donnell. I was going to ask you if that is section 701 (f).

Dr. Babcock. What page?

Senator Donnell. At the bottom of page 105, and the top of 106, was that the section to which you refer?

Dr. Babcock. Yes, sir, that is right.

Senator Donnell. It provides:

> "Auxiliary services" consist of such chemical, bacteriological, pathological, diagnostic X-ray and related laboratory services; X-ray radium, and related theraphy; physiotheraphy, services of optometrists and chiropodists; and prescribed drugs which are unusually expensive, special appliances, and eyeglasses; as the board, after consultation with the Advisory Council, by regulation designates as auxiliary services on the basis of its findings that their provision under this title is practicable and is essential to good health care.

That only applies in S. 1679.

It is not mentioned by name in any of the other bills, and that is the only place?

Dr. Babcock. That relegates us to an auxiliary service, which we are not.

Senator Donnell. Doctor, I have called your attention, as you undoubtedly observed numerous times, that in determining which of these various services, including those of optometry, shall be included in auxiliary services, it is this board, this National Health Board, after consultation with the Advisory Council, by regulation, which determines that fact, that is correct, is it not—page 106, line 4, and following.

Dr. Babcock. That is right.

Senator Donnell. And that is the same identical board that we were talking about here when the preceding witness was on the stand. It shall all be administered under the direction and supervision of the Federal Security Administrator, that is right, is it not?

Dr. Babcock. As I understand it.

Senator Donnell. So ultimately, in determining whether or not the services of optometrists, under this S. 1679, are to be considered even as auxiliary services, or whether they are to be embraced within these auxiliary services depends on what the regulations of the Board shall be after it has consulted with the Advisory Council, and that Board which makes that regulation, performs all of its functions as stated on page 137, and following, under the direction and supervision of one Federal official, the Federal Security Administrator, is that correct?

Dr. Babcock. That is the way I see it.

Senator Donnell. Thank you.

Senator Murray. Doctor, I notice that the New Jersey Optometric Association issued a statement on May 23, 1949.

In this statement, I find the following language:

> Charting a course which neither endorses nor condemns the several highly controversial national health bills now before Congress, the New Jersey Optometric Association today issued a resolution which recommends that, "All legislation pertaining to a national health program, such as embodied in S. 1456, S. 1581, and S. 1679, be amended to guarantee, to beneficiaries of a national health program, protection and preservation of their right to avail themselves of the

professional services of optometric practitioners without prior approval by a medical administrative officer or a physician; to provide for assistance to colleges of optometry comparable to that proposed for their health professions; and to include representatives of the optometric profession on boards and councils established to administer public health programs."

Now, I will ask that this be carried in the record.

(The article referred to is as follows:)

Optometrists Urge Professions Accept Public's Decision on National Health Legislation

Charting a course which neither endorses nor condemns the several highly controversial national health bills now before Congress, the New Jersey Optometric Association today issued a resolution which recommends that, "all legislation pertaining to a national health program, such as embodied in S. 1456, S. 1581, and S. 1679, be amended to guarantee, to beneficiaries of a national health program, protection and preservation of their right to avail themselves of the professional services of optometric practitioners without prior approval by a medical administrative officer or a physician; to provide for assistance to colleges of optometry comparable to that proposed for other health professions; and to include representatives of the optometric profession on boards and councils established to administer public health programs."

The resolution buttressed the association's stand by pointing out that optometrists now serve more than 80 percent of our citizens who obtain visual care; and receive more than 4,000 hours of study, laboratory, and clinical experience in many medical subjects as compared with less than 100 hours of formal instruction in all matters pertaining to the human eye received by general medical practitioners. The resolution further pointed out that optometrists are the only professional group specifically licensed to render visual care, are the largest group specializing in vision, and are more widely distributed than other eye doctors.

Announcement of the resolution followed, by 3 weeks, an address made by Senator James E. Murray, a leading proponent of the administration-sponsored health bill, at the association's annual meeting in Asbury Park on May 1. On that occasion Senator Murray said in part

"* * * optometrists care for more cases of maladjusted vision in a month than the general practitioner of medicine handles in a year. Because of this situation they are urging that we change the national health insurance bill to provide that people covered by the act go directly to doctors of optometry without referral from doctors of medicine if they so choose.

"Now the United States is well ahead of the rest of the world in proportion of physicians to population. If, despite this, American medicine is correct in its contention that doctors of medicine simply cannot provide primary medical care for the health needs of our people once we remove the economic barrier between the doctor and the public, then I am confident that members of my committee will want to give careful attention to the proposals of American optometrists."

In commenting on the resolution, Dr. Harold Bookstaber, president of the association, stated:

"The American people receive the finest visual care available anywhere in the world today—principally from optometric practitioners. Anything that interferes with the individual's right to free choice in the selection of an eye doctor will most certainly reduce the quality of visual care much below its present high level. Forcing patients to get a physician's permission to visit an optometrist, he said, is a time-wasting, expense-adding procedure that will probably create coercion and a resurgence of fee-splitting and kick-back practices for which many medical eye doctors were recently indicted and fined.

"We consider it highly improper for organizations of doctors to argue and propagandize for or against basic proposals on how the American people shall pay for their health services. It is the people's health and the people's money which is at stake and the people, through their duly elected representatives, have the right to decide how they will protect their health and spend their money. This in no way limits an individual doctor's right or obligation to make known his own views as to any clause which may be found in such program nor does it limit the right and obligation of organizations to so express themselves. It is merely a recognition of the fact, under our democratic system, that no one group of practitioners is justified in assuming the right to dictate to the American people how they shall protect their interests."

I am sure optometrists throughout the Nation will willingly abide by the public's decision in this matter and will pledge themselves to continued observance of high standards of practice and professional integrity in preserving and guarding their fellow-citizens' most treasured faculty—good vision.

Copies of the resolution have been sent to President Truman, Senate President Barkley, Speaker of the House Rayburn, members of committees considering health legislation, and New Jersey Senators and Congressmen.

Resolution

Resolution Adopted at the Forty-sixth Annual Meeting of the New Jersey Optometric Association, May 2, 1949

Whereas good vision and its conservation is essential to the preservation of health, general well-being, and personal efficiency; and

Whereas efficient vision is of paramount importance to the national security and welfare as was conclusively demonstrated by high draft deferments for visual defects and by problems of industry arising out of visual defects during World War II; and

Whereas the profession of optometry by reason of specialization in visual care ministers to the visual needs of more than 80 percent of our citizens who seek professional care in matters of vision; and

Whereas optometric education and training require more than 4,000 hours of highly specialized study which includes human anatomy, bacteriology, chemistry, general pathology, physiology, psychology, physiological optics, geometric optics, theoretic optometry, practical optometry, visual training, etc., and extensive laboratory and clinical experience; and

Whereas general medical practitioners receive less than 100 hours of formal instruction in all matters pertaining to the human eye; and

Whereas optometrists are required to pass exacting written and practical examinations in the above-mentioned subjects to qualify for licensure in the several States; and

Whereas optometry is recognized and legalized by statute in the several States as an independent profession, apart, distinct, and distinguished from the medical profession; and

Whereas optometrists constitute the only professional group specifically licensed to render visual care; and

Whereas optometrists constitute the largest professional group specializing in visual care and are more widely distributed throughout the Nation than other eye doctors; and

Whereas proposals for a national health program known as the Hill bill (S. 1456), the Taft bill (S. 1581), and the Thomas bill (S. 1679), all of which involve the use of Federal funds and all of which involve the provision of visual care, are now before the Congress of the United States and are being widely discussed in the press, over the radio, and before public gatherings; and

Whereas it is in the national interest that any national health program, whether voluntary or compulsory, Nation-wide, industry-wide, or based upon any other groupings, should, in consideration of available professional personnel, geographic distribution, public preference, need, economy, practicality, efficiency, and the general welfare, provide for the utilization of optometrists as independent practitioners rather than as members of an auxiliary service: Now, therefore, be it

Resolved, That the members of the New Jersey Optometric Association recommend that all legislation pertaining to a national health program, such as embodied in S. 1456, S. 1581, and S. 1679, be amended to guarantee, to beneficiaries of a national health program, protection and preservation of their right to avail themselves of the professional services of optometric practitioners without prior approval by a medical administrative officer or a physician; to provide for assistance to colleges of optometry comparable to that proposed for other health professions; and to include representatives of the optometric profession on boards and councils established to administer national health programs; and be it further

Resolved, That the enactment of any legislation involving the provision of visual care, which does not so provide, shall be vigorously opposed by the members of this association, their patients, friends, and all who believe in the American right of freedom of choice; and be it further

Resolved, That copies of this resolution be presented to the President of the United States, the President of the United States Senate, the Speaker of the House of Representatives, sponsors of the several bills herein enumerated, members of the Senate and House committees of the National Congress considering bills dealing with the subject matter of this resolution, the Senators and Representatives from New Jersey, officers of the American Optometric Association, the presidents and secretaries of State optometric associations, and the public and optometric press.

Senator DONNELL. I want to correct probably an inaccuracy. I think it was an inaccuracy in one of my questions. I intimated, I think, that the Board can determine whether any services of optometrists shall be considered auxiliary services. I am not at all certain that under this language, in 701, that the Board can include all services of optometrists. That may be somewhat ambiguous, but the discourse is such that it says that auxiliary services consist of such services, and optometrists are contained therein—

as the Board, after consultation with the Advisory Council, by regulation designates as auxiliary services—

and I would not want the record to be closed on this point with any intimation on my part that that necessarily means that the Board has the right just to exclude optometrists entirely. It may be that they have to admit them to some extent, but I am not certain that they have the power to exclude them entirely.

Dr. BABCOCK. If the man was a medical director and didn't like optometry, he might refer all people that came to him to other medical men.

Senator DONNELL. Now, without any reflection on the profession of the chiropodist, I notice that the services grouped in 1679 were the services of optometrists and chiropodists.

Do you think that the services of the two professions are of equal importance to the efficiency of the patient?

Dr. BABCOCK. I think you can get along with corns on your feet better than you can without seeing.

Senator MURRAY. You don't feel very comfortable, though. I patronize a chiropodist.

Dr. BABCOCK. I have one next door to me.

Senator MURRAY. And I finally got a line on a shoe that fits your foot just perfectly, and now I have no trouble at all.

The trouble with most people, the trouble they have with their feet is that they don't have a shoe that fits, and if you have a shoe that fits you, all right; but I think the chiropodist is an important profession, too.

Senator DONNELL. I think it is too. I didn't mean any reflection on them at all. I have some personal knowledge of the profession of chiropodist myself, but as I understand your point, you deal, as optometrists, with vision and a man has to be able to see before he can function, very conveniently, if you are pursuing work requiring reading and things of that sort.

Now, I can well understand the importance of chiropody, and I don't want anybody, as I say, to interpret anything I say as a reflection on that profession. It is not so intended, but you are of the opinion that the eyes are relatively more important; that is, the treatment of the eyes and the preservation of vision is relatively of greater importance. I will say, and perhaps that would rank somewhat more important than at least that portion of the work of the chiropodist which has to do merely with administering to the comfort of the individual. Am I right?

Dr. BABCOCK. That is right, but we believe that optometry should be in the same category as medicine and dentistry, because it is an independent profession and has been for 50 years. All the advances that have been made by optometry in the visual science have come after long and careful training, and we don't believe—I don't want to belittle the others down there, but I think it is of major importance that the care of the eyes be up along with the top, because we are regulated in every State in the Union, and the District of Columbia, and there is no profession that has the amount of education required for such a limited field of health care; no profession spends 4 and 5 years on the care of vision; that is a greater proportion of knowledge than any other profession has, and I think that it is important enough to rank right along with medicine and dentistry.

Senator DONNELL. I want to make it perfectly clear again, even at the expense of some repetition, I mean no reflection upon chiropodists. I know the members of my family have found it absolutely essential to secure the services of a chiropodist, and great discomfort and suffering would have resulted had not their services been rendered.

So, I want that clear in the record, that I pay all due respect to that profession, and I mean no reflection upon it in the questions.

Dr. BABCOCK. Off the record, we have one on each side of our office on our street, and both are fine men and doing a lot of good.

Senator DONNELL. I have nothing further, Mr. Chairman.

Senator MURRAY. Thank you, doctor.

There is a debate on the floor this afternoon and it will be impossible for us to be here, so I would request the witnesses that would appear this afternoon to file their statements, and if they wish to make any personal statement at this time, they may come forward and make it; but if they will file their statement for the record, they will have the same effect as if they read them right here in the hearing room.

Are any of the witnesses here?

STATEMENT OF DR. H. WARD EWALT, JR.

Dr. EWALT. I am H. Ward Ewalt, Jr., and I reside at Pittsburgh, Pa. I am chairman of the council on education and professional guidance of the American Optometric Association, and optometric consultant to the Office of the Surgeon General, United States Army. I am a fellow of the American Academy of Optometry, and a practicing optometrist.

If I may, I will summarize the statement in just about 1 minute.

Senator MURRAY. All right, sir, you may proceed.

Dr. EWALT. If you will turn to page 5 of my prepared statement, the statement deals with the following points:

1. By reason of superior education, the optometrist is the best prepared specialist in the field of vision.
2. Optometry has grown educationally and scientifically as an independent profession.

3. At least 70 percent of the American people choose to go to an optometrist rather than to any other specialist in this field.

4. Optometrists are widely distributed even in semirural areas which makes their services readily available to the people.

5. Vision and its related problems are important factors in the health and welfare of our people.

For these reasons optometry in every national health program should be included as an independent profession.

Optometry should be included by name in titles I, II, and VI to insure continued growth and improvement in the education and research programs of the profession and in title VII to insure the beneficiaries of the plan the freedom of choice declared to be the congressional intent.

Senator MURRAY. Thank you, Doctor.

I notice there where you say, in point 4, "Optometrists are widely distributed even in semirural areas which makes their services readily available to the people."

My understanding is that it is the practice for an optometrist sometimes to advertise that he will be in some of the rural places on a certain day in a week, and then he can take care of that rural section in that way.

Dr. EWALT. That used to be the practice, because of the large numbers of vision problems that occur among any group of people, they are established in permanent offices in semirural areas, even, whereas, to seek the services of the ophthalmologist, many of our citizens, the majority would have to travel hundreds of miles to where an ophthalmologist is located.

Senator MURRAY. Thank you very much, Doctor.

(The statement submitted by Dr. Ewalt is as follows:)

STATEMENT OF DR. H. WARD EWALT, JR., CHAIRMAN, COUNCIL ON EDUCATION AND PROFESSIONAL GUIDANCE OF AMERICAN OPTOMETRIC ASSOCIATION

My name is H. Ward Ewalt, Jr., and I reside at Pittsburgh, Pa. I am chairman of the council on education and professional guidance of the American Optometric Association, and optometric consultant to the Office of the Surgeon General, United States Army. I am a fellow of the American Academy of Optometry and a practicing optometrist.

The council on education and professional guidance of the American Optometric Association is responsible for the following functions:

1. Changes in type and amount of educational training that may be needed as experience indicates, and as changing conditions warrant;
2. Matters concerning the qualifications of the present and future schools, minimum content of curriculum, number of teachers, laboratory equipment, and so forth;
3. Matters concerning developments of an educational character such as admission requirements, length of course, degrees, et cetera, and
4. Inspection and accrediting of schools and colleges conducting courses of instruction in optometry.

There are 9 accredited schools and colleges of optometry. The present standard course is 4 years at the college level. Several schools are already giving 5-year courses. Commencing September 1st of this year, all schools will give a minimum of 5 years at the college level as the educational preparation for the State board examinations. The curricula of these schools is based on a complete and thorough training in physical problems and aspects of vision, in the function of physiology of vision, and on the psychology of seeing or the interpretation of our environment through vision and the application of these sciences to the visual problems of human beings. It is my considered opinion that beyond all question of doubt the optometrist has a vastly superior training to any other group practicing in this field.

Optometry is, on the basis of history, State supreme court decisions, legislation, and education, a completely independent profession. When refracting opticians (optometrists) first taught medical men to refract in the city of Philadelphia in the 1870's there began a sharp economic rivalry. In spite of medicine's numbers, prestige, propaganda facilities and financial resources, medicine remains today, after 75 years, a distinctly minority group in the field of vision care. This result was made possible because optometry has been organized and maintained as an independent profession, thereby affording the American people an opportunity to make a choice. This choice they have made in no uncertain terms. As Dr. Babcock has already pointed out, 90 percent of the American people at some time seek vision care and at least 7 our of 10 of them choose to go to an optometrist.

I am sure that it is not the purpose of this committee or this Congress to legislate in such a way that the American people will not have a free choice of practitioner—a choice which they have clearly expressed over a period of at least 75 years. Nor do I believe that it is the purpose of this legislation to destroy the independence of the important optometric profession and to subject it as an auxiliary service to the whims of a powerful group that, on the basis of a free enterprise and a free choice of practitioner, has been able to secure only 30 percent of the available patients.

Most of Dr. Babcock's testimony related to the operation of title VII of S. 1679. I am sure that as informed citizens we all agree as to the importance of vision to our civilization, especially as it relates to education and children, industry, industrial safety and production; therefore, we will not burden you with statistics and expert opinion on this subject because they would run into several volumes.

There are two other titles, however, about which I should like to speak.

Title I of S. 1679 provides for education of health personnel and education in the following professions, specifically named: "Medical, dental, dental hygiene, public health, nursing, sanitary engineering, hospital administration." All of the things that I have said about the importance of vision care, about the function of optometry as an independent profession, have particular bearing and importance on this title of the act. Optometrists are widely distributed and practice successfully in relatively small centers of population, while in many sections of the country it would be necessary to travel hundreds of miles to find an ophthalmologist. The numbers and wide distribution of optometrists makes them readily available to the vast majority of our people. Certainly optometry should be specifically named in this title in order to insure the education of the vision specialist who is widely available even in semirural areas.

It might be said that the bill goes on to read "and related professions," and that optometry might be included in a construction of this phrase. Perhaps it might be, but the function of optometry as has been demonstrated is too important to be left to chance interpretation. This has been done in the past with the result that optometry has been discriminated against and the public has suffered. Therefore, we respectfully request the inclusion of optometry by name in title I.

Likewise in title VI which provides for research in child life and grants to States for maternal and child health and crippled children's services, there is no mention in section 611 of optometric services and facilities. There is no point at which optometry makes a more important contribution than in preventive and corrective work with children. It is not yet widely known, although carefully controlled research at several universities supports the statement, that one of the most important interferences with achievement in schools is the lack of the necessary visual skills to cope with the modern school program. Certainly this is a field in which additional research could and should make important contributions to the prevention and correction of the visual problems of children.

Part of our failure in this field was pointed up during the recent war by the Selective Service Administration which reported that the greatest cause for rejection of adults was first, dental defects, and second, visual defects. Both of these greatly exceeded the next category.

In conclusion, we have pointed out that—

1. By reason of superior education, the optometrist is the best prepared specialist in the field of vision.
2. Optometry has grown educationally and scientifically as an independent profession.

3. At least 70 percent of the American people choose to go to an optometrist rather than to any other specialist in this field.
4. Optometrists are widely distributed even in semirural areas, which makes their services readily available to the people.
5. Vision and its related problems are important factors in the health and welfare of our people.

For these reasons optometry in every national health program should be included as an independent profession.

Optometry should be included by name in titles I, II, and VI to insure continued growth and improvement in the education and research programs of the profession, and in title VII to insure the beneficiaries of the plan the freedom of choice declared to be the congressional intent.

Senator MURRAY. Are there any other witnesses?

Miss HALL. I am Helen Hall.

Senator MURRAY. I remember you, Miss Hall.

STATEMENT OF HELEN HALL, DIRECTOR, HENRY STREET SETTLEMENT

Miss HALL. As you know, Senator, I am director of Henry Steet Settlement, representing the National Federation of Settlements and Neighborhood Centers.

I am glad to be here, and will be glad to put our testimony in the record; but I have a part of a letter here and which is not in my testimony and I wonder if I might be permitted to read it?

Senator MURRAY. You may.

Miss HALL. It comes from someone whom I have known, who was in a club which was once a girls' club. Now, of course they are all women of my age, and I may say this letter just came this week and I feel that I would like to have part of it in the record as it illustrates the kind of problem that I am speaking of in my paper and which all settlement workers are up against so many times.

She says, and this is from the mother of a boy and she is writing about his college problems:

> I am desperate. Ted has graduated and is out of school. We both had day dreams and, I guess, visions of him going to Notre Dame, but since I have had so much trouble and sickness, it has drained every penny of my savings. I often hear people say "money talks" and now I have come to realize that. For three long years I have had nothing but doctors and hospitals bills with Frank and myself, and Frank out of work for 4 months. So, all the money I had saved for Ted's education went fast. Well, we gave Notre Dame up and shopped around for the cheapest college we could find, which cost $450 a year and we thought that if Ted could get a job for the summer and after school for winter, we could swing it. Jobs are very scarce here.

Of course this is in Philadelphia, where I work.

> I guess is is the same all over. We have been trying for months, as far back as April——

And then she goes on to tell some more news, and about her difficulties in getting a job for the boy and asking if I could possibly help her in any way.

This is a fine family, as fine as I have ever known in any of my 25 years of work, and I know what it has meant to them to have to spend the money on their own health when they need it for the boy.

I might say that the father worked for 34 years with one firm and the firm closed their Philadelphia office and moved west and left him without any resources, that he is a man in his 50's and took night work at the post office, and has been out of work for 4 months.

Senator MURRAY. You have stated in your article all the pertinent facts in connection with your case.

Do you want the letter in, in its entirety, or have you stated all the facts that are relative here?

Miss HALL. I would like at the end of my own statement, if I may, Senator, to put in my statement.

Senator MURRAY. Very well.

(The complete statement of Helen Hall is as follows:)

STATEMENT BY HELEN HALL, DIRECTOR, HENRY STREET SETTLEMENT, FOR THE NATIONAL FEDERATION OF SETTLEMENTS AND NEIGHBORHOOD CENTERS

The neighborhood houses making up the National Federation of Settlements are located in 74 cities in 27 States and the District of Columbia.

In the larger urban centers, there are city federations which can speak for from 5 to 40 such houses. Elsewhere, individual houses carry on in the industrial neighborhoods of smaller cities, or pioneer in semirural areas.

The settlements are aware of what life brings to their communities; they know families in sickness and in health.

This is why American settlements first passed a resolution favoring health insurance in 1917. Repeatedly we have reaffirmed this position, and backed it up with first-hand studies of household experience.

And that is why nearly a third of a century later, our national federation, meeting in Cleveland early this month, adopted a resolution strongly urging the passage of Senate bill 1679, which would implement the rounded national health program, recommended by the President. I am here representing the National Federation of Settlements.

I shall not deal with statistics or the technicalities of the various bills so much as speak of the people behind them with whom we work. And because of our firm belief in compulsory health insurance I shall take up particularly article VII in S. 1679 which deals with this controversial issue.

This is not to say we do not know at first hand the need for other provisions outlined in the earlier six articles that make up the bill. We must have more doctors, more nurses, and more dentists in the United States of America. There are by no means enough to go around. More hospital beds are needed and so is the planning required to put hospitals where incidence of sickness is high and incomes are low, and to put modern diagnostic facilities within the reach of all who need them. We need public health reaching into the smallest towns and country districts; need rehabilitation for the 250,000 men and women disabled each year; need further development of maternal and child welfare services; we need the expansion of medical research with cancer, heart diseases and mental health taking precedence; and strongly, from our standpoint, we need the expansion of dental services for children's teeth.

Then as a first line of defense we need compulsory health insurance reaching into every neighborhood and bringing protection and reinforcement to the humblest home.

The point for me to stress very strongly is that we of the settlements see that the problem of health in our neighborhoods hangs primarily on purchasing power. In the large, in our American cities, doctors' services in or out of the home, hospital beds, diagnostic services are all available now, to those who are able to pay for them.

If advances in the economics of medicine had gone as far as advances in medical science, we would be well on our way to universal health as a Nation. But we have left the distribution of medical care almost entirely to its practitioners when it is really a problem for the whole community and the whole Nation to solve.

Fortunately, recognition of this principle has widened since 1917 when we passed our first resolution. Would that it were wider! Many of us hope that the Social Security Act of 1935 would include the protection of health as one of its major provisions. In spite of 14 years of furious discussion since the passage of that act, we have not rounded out our social-security system. We can be glad, however, that the four major bills before the Eighty-first Congress show how far our thinking has gone ahead in spite of great differences. All four bills acknowledge at least that the American people require some modern organized help in meeting their needs when sickness strikes.

A second point of agreement is that Federal funds must play a large part in any wider distribution of medical care.

Moreover, there is widespread agreement in the community that 80 percent of the population, made up of families earning less than $5,000 yearly, should be drawn into a plan which would genuinely safeguard their health.

As I see it, leaving aside the technicalities of the outstanding bills put before you, the most important and basic points of difference can be simply stated:

Thus, I see no way that the provisions of the Taft bill or the Hill bill could be carried out without a "means test."

The Flanders-Ives bill not only relies on Federal subsidies to private prepaid health-service plans, but calls for a 3-percent minimum voluntary pay-roll tax on "the subscriber's family income."

These are offered as alternatives to the compulsory insurance provisions of the national health program embodied in S. 1679, which would require a 1½-percent wage deduction from the worker and a 1½-percent contribution by the employer and no "means test."

The history of social advance goes to show that any large-scale forward move tends to engender emotion and hysteria. It seems to me compulsory health insurance heads the list in this respect. To this day we still have to combat the idea that health insurance would lead to regimentation of doctors, that it would destroy doctor-patient relationships and afford no free choice of physician. It isn't only organized medicine that raises this hue and cry. Doctors I meet everywhere tend to say the same thing without knowing the provisions of the bill.

It may surprise you if I report that my neighbors go right along with the American Medical Association in feeling that the doctor-patient relationship is very important. They certainly crave a free choice of physician. But at that point their agreement ends, for those in the lower-income brackets have found through hard experience that the "free choice" and continuing relationship is all too often a matter of being able to pay for it.

According to a study we made in our neighborhoods throughout the country some years ago, our settlement federation found that only one-third of our neighbors had what might be called a family doctor. This was in many cases not what you and I would call a family doctor but someone with whom they had something more than an emergency relationship—and credit.

So much has been said, and rightfully, about the generosity of members of the medical profession that I would like to pay tribute to the sense of responsibility toward paying the doctor which I know the majority of my neighbors feel. As a whole, they expect to pay at the time they see the doctor, and the doctors expect them to. Today the fee for a home visit in my neighborhood on the East Side of New York is seldom less than $5, and $3 to $5 for office visits. It is one thing for the mother of the family to consider whether they can afford meat for dinner, but it is another thing for her to have to consider whether she can afford to call a doctor when her children are sick. In our neighborhood the parents very often wait to see whether the fever is going to be high enough to make sending for the doctor a necessity.

I don't know whether you are familiar with what is done in New York City if sickness comes when the family hasn't enough money for a doctor, and the patient is too sick to get to a clinic. They send for a city ambulance, or a neighbor or visiting nurse or social worker does this for them. There used to be a doctor on the ambulance. Now it's more often an attendant along with a policeman and a driver—all out for one neighborhood call—and they can't treat the patient when they get there. An on-the-spot decision is made as to whether the sick one is sick enough to be admitted to the hospital, otherwise the man, woman, or child is left to get well as best he may.

Surely harassment in relation to payment does not improve the doctor-patient relationship, and I should think doctors would be the first to want a change. Money paid at a hard and anxious moment, borrowed from a friend next door or a relative down the street, must embarrass the doctor as well as add strain to illness. Many a doctor can, I know, say with justice that some patients have not been conscientious in paying, but to me this is only another argument for insurance. An unpaid doctor's bill is good for neither doctor nor patient.

So much for day-to-day emergencies in normal family life, particularly when there are growing children. The dread of catastrophic illness forever haunts the poor. The rapid spread of medical plans and the claim that they cover from 45 to 55 million people surely show how hungry Americans are for medical security. But what is not borne in mind is that estimates indicate that only 2½ to 4 million of these same folks are covered by a comprehensive plan such as the President's health program envisages, which would take on both day-to-day emergencies and major sicknesses that become household calamities. It certainly must be acknowledged that the total cost of this kind of coverage is too high to be met by a large majority of families. What health insurance holds out is a wider sharing in the benefits of modern science. This in the long run will pay dividends in creative power and productivity to the whole country.

A study of war workers' budgets was made by the National Federation of Settlements in the early forties. We were not surprised to find that many of these workers then earning good wages had to clean up debts overhanging from 10 years of hard times. What did surprise us was that approximately five out of seven families told us of heavy medical and dental expense during the war years—some so large, ranging from $200 to $800 that it was clear they were trying to make up for neglect during the depression.

Often medical bills are larger because our neighbors have exercised the right of free choice of physician rather than go to a clinic where they cannot choose. And, too, the difficulties involved in taking babies and small children and waiting hours to be seen by a clinic doctor are frequently overlooked by outsiders; also the loss of time and wages on the part of bread winners.

People still talk lightly about free choice of physician without comprehending that it is not usually found in clinic or hospital ward, or anywhere without money to pay for it. I made an arrangement the other day with an experienced doctor I knew to see a small boy whose mother is a member of Henry Street Settlement. I told her to ask for this physician when she got to the clinic. She did ask for him and was met with, "You should know you can't ask for any doctor by name here."

It is refreshing to see in S. 1970, introduced by Senators Flanders and Ives, a plan where consumers of medicine would play a leading role in its distribution. But the bill proposes voluntary payments of not less than 3 percent of the family income all to be paid by the family, with the employer permitted to contribute in some way if he chooses. Like other voluntary plans this tends to protect those least needing protection, for the less the family income, the greater the pressure on the family dollar. When it is a question between milk and voluntary insurance it is hard not to gamble on keeping well and buying the milk. Yet it is these very families, self dependent, though operating on a shoe string, whose needs are greatest because their reserves are less. They will get adequate protection only through a low-cost compulsory system of health insurance.

While voluntary insurance plans and group practice were still the objects of bitter vituperation in medical circles, I was eager to see them tried out as a means of experimental action and a way of advancing the distribution of medical care in middle-income groups, who certainly needed something better than they were getting under the old system. However, I never thought for a moment that they would prove to be the answer for the rank and file of my neighbors. Today these plans seem to have become almost a vested interest, a barrier rather than a road leading to a broader coverage for everybody.

The Flanders-Ives bill, as well as the Hill bill, proposes giving subsidies to voluntary plans. Why the health of the people should be so much safer in the hands of private organizations than in the hands of their appointed representatives, I do not understand. Nor why the average citizen would have less to say about how his Government runs something than subscribers have to say about most voluntary hospitalization plans.

Surely the Government has made the grade in administering the Social Security Act. People of caliber and ability have directed it. My personal experience would indicate that it has worked out with a maximum of satisfaction from Washington to Albany, to Henry Street. As for the objections of the American Medical Association to health insurance, one can hardly feel confidence in the sense of social responsibility of an organization which, either nationally, or through local affiliates, has opposed in turn such gains as: Workmen's Compensation, Federal aid for infant and maternal health, hospital insurance and medical care insurance, group health practice, vaccination of children in public health centers, expansion of public health activities, and even Red Cross blood banks for civilians.

The AMA and its affiliates have endeavored to hamstring the long-deferred expansion of Federal social security to cover the hazards of sickness. Under their rear-guard pressure even laws have been passed in 22 States to restrict voluntary health organizations to medical sponsorship. A modern partnership is long overdue between the profession which renders medical service and the consumers who receive it, within the framework of government which represents us all and has the resources and authority to assure minimum health standards for Americans everywhere.

The other night I asked the up and coming members of a young mothers' club at Henry Street Settlement how many of them had any kind of health insurance. There were 27 of them and their family incomes were above the average for our neighborhood, ranging from one at $1,800 to one at $6,000—a majority of them between $2,500 and $3,500. Fourteen of them had some kind of hospitalization and the one with a $6,000 income had taken out a sickness insurance policy in a private company in Omaha. Two others had partial coverage of this kind. The one with the $1,800 had dropped her policy because she could not keep it up. The Blue Cross accounted for five of the plans; others included those of the Knights of Pythias, the Police Benevolent Association, two trade-unions, a business firm, the postal clerks, and the Post Office Department Letter Carriers' Sick Benefit, and three commercial company plans.

It was a chaotic picture with all sorts of complications. As one woman put it, "They have so many clauses in the contract that you have to read them all or else you end up not collecting." Another said, "What we want most is a doctor when we are sick, I mean just sick; not operated on or in the hospital." Another felt "It was the prevention side" that she looked at; "I'd like to get medical examinations for the children and not let little things go so long they get big," "We take chances with our kids," volunteered a bright-eyed girl with three very young children whose husband earned $4,150. "Now the Blue Cross has gone up and with the new baby, I just can't find the money to pay for it another year, but I thought I ought to take it this year because I had two babies under it and I owed it to them." Another said, "We could take preventive measures; our children have care, but if we should go to a doctor think of the $5. We wouldn't take advantage but we would feel we could see the doctor."

It would be hard to know this group of women or their like elsewhere and still feel that a health bill which excluded the self-dependent was a real answer, and I assure you they wouldn't think so either.

What we in the settlements want to see done is a fund built up through compulsory insurance which would bring health protection to more people as a right. I feel that self-respect and self-reliance have helped make our country great. But which is the more self-respecting thing to do—which would you or I like better—to have a small deduction from our wages with medical care as a right when we need it, or not to have this compulsory payment and to have to be declared "medically indigent" by way of a means test to get help when sickness strips us of personal reserves.

Dr. Irons, president of the AMA, put it this way at the Conference of Social Work last week, "The recipient must be told that he is a part of his community and that for every recipient of largesse, someone else must work a little harder." Imagine telling a wage earner who has just discovered that he has cancer, that "someone is going to have to work a little harder" to take care of him. That certainly throws psychosomatic medicine out of the window.

Unless you are very close to the average family you cannot realize how hard they struggle to maintain their self-dependence or realize the sense of humiliation that comes with failure. We have learned so much in recent years about the effect of pressure and failure on physical well being that we might well hesitate to put a family in the indigent class, even though, to use the current term, it is only "medically indigent." Indigent is an ugly word and you will not find this term employed in the bills under consideration even when it is used as a yardstick.

To go back to the experience of the young New York housewives I have spoken of: One reported a dental bill of $125 and $250 in medical bills during the year, another $250 for medical care and $100 toward dental, another $100 for dental care and $200 for medical, all this last year—another's veteran husband had spent $80 on one tooth. "By a technicality," she said, "the tooth didn't come under the Veterans' Administration." On the other hand, another said her husband had had so much medical care through the Veterans' Administration that they would have been on relief if they had had to paid for it all.

As a matter of fact, 22 percent of relief applicants in New York City come on the rolls of the Department of Public Welfare because of temporary illness. This brings up another anomaly springing from the fact that we have built our social-security system piecemeal. We pay unemployment insurance to a worker who has lost his job and is well, but if he is sick and hence out of work and needs the money much more, he has no insurance.

It happens that I served on unemployment commissions in the very early days of the depression and later on the President's Advisory Committee in setting up the Social Security Act. All during those years I was told how terrible it would be for the United States if we had unemployment insurance. No one would want to work again and individual initiative and free enterprise were doomed.

Well, as for not wanting to work, America's productive capacity during the war years showed what men and women who had needed relief and unemployment insurance could do when once they got jobs.

Today with an increase in unemployment, I am sure many of those who felt that unemployment insurance would wreck the country are very glad indeed to have the cushioning effect of this new type of purchasing power as a brake on the business cycle. From another angle can't imagine the difference it makes to the family, and to us, when the mother says those awful words, "He's out of work," to know there is unemployment insurance to at least keep the groceries coming in.

Similarly, in the early movement for public housing, we were told that it would wreck the country. This time private initiative would go by the board and people would be pauperized. At the time I lived opposite an old, filthy, rat-infested tenement on Henry Street, and I couldn't but wonder how any intelligent person could seriously think it was propitious for the initiative, health, morals, or anything else for the families who lived there. Now one of the first of the public housing development has taken its place. It has brought cleanliness, sunshine, air, trees, and much pride and satisfaction to all of us on Henry Street, let alone those families who are lucky enough to call it home. I don't take a rosy view of everything we do through Government, but from the close-up I have had of our housing authority, it has stood up under the terrible pressure for shelter of these postwar years, with intelligence and honesty.

I cannot but relate my experiences with these two great social measures which were so reviled and feared at the time of their passage to the measure before us today. I have seen the first two enacted and reach down into my neighborhood and lift the level of life for my neighbors.

I understand that health is not on your must list this session of Congress. You can choose, but sickness will be on the must list of millions of American families this year and they cannot choose.

Senator MURRAY. Who is the next witness?

Mr. ANDERSON. I am, Senator.

Senator MURRAY. Very well, sir; you may proceed.

STATEMENT OF JOSEPH P. ANDERSON, EXECUTIVE SECRETARY OF THE AMERICAN ASSOCIATION OF SOCIAL WORKERS

Mr. ANDERSON. My name is Joseph P. Anderson. I am the executive director of the American Association of Social Workers, and I wish to file a statement that I had prepared for presentation this morning.

I also want to say that I am happy that, in addition to our organization, two other organizations, the American Association of Medical Social Workers, which includes about 2,300 members in all sections of the country, and the American Association of Psychiatric Social Workers, which has about 1,400 members, that these two associations have also taken action endorsing the position which is stated in my testimony, and I would like to read, on behalf of the American Association of Psychiatric Social Workers, the following:

At the annual meeting of the American Association of Psychiatric Social Workers in Cleveland, Ohio, the recommendation of the National Social Action Committee, that the membership take action favoring a national health program which includes compulsory health insurance was accepted by an overwhelming majority. His group represents a membership of 1,367. The executive committee voted unanimous approval before submitting the recommendation to the approval of the membership.

I remember with pleasure my appearance before the committee 2 years ago when Senator Donnell was in the chair, and I am sorry that there is not an opportunity for discussion of the statement.

I am very happy to file the statement.

Senator MURRAY. I am willing to have you go down to Senator Donnell's office, and he will cross-examine you.

(The full statement of Joseph P. Anderson is as follows:)

STATEMENT OF JOSEPH P. ANDERSON, EXECUTIVE SECRETARY OF THE AMERICAN ASSOCIATION OF SOCIAL WORKERS

THE NATURE OF OUR ORGANIZATION

The American Association of Social Workers is a national organization of professional social workers. It was founded 26 years ago and now has 11,500 members living in all parts of the United States and its territories. These social workers are employed in public and voluntary local, State, national, and international agencies. The association has about 100 chapters located in practically every State.

OUR RESPONSIBILITY

We have learned through our experience as social workers that health next to unemployment has taken the greatest toll in economic and social well being. In working with people we have seen the effects of the break-down in health upon family life and care of children. As a professional group we feel that we have a responsibility to make what we have learned known to those who must decide upon national programs which will affect all of the citizens for years to come. We would like to express our appreciation for this opportunity to present our views on the legislative proposals embodied in S. 1456, S. 1581, and S. 1679. Also we shall comment briefly on S. 1970.

PLATFORM ON HEALTH AND MEDICAL CARE

For more than 10 years the association has been studying health needs because its members were concerned about means of preventing the resulting break-down in family and community life. We evolved gradually the principles on which we believe a national health and medical-care program should be based. Our annual conference, attended by delegates chosen by each chapter, provides the chief means of formulating membership opinion on national issues. The annual delegate conference, las held in April 1948 in Atlantic City, N. J., adopted a platform on health and medical care. I am empowered to present the association's point of view on any national health legislation in relation to the principles, which we adopted.

OUR GENERAL POINT OF VIEW

The American Association of Social Workers believes that a national health program is an essential and integral part of a broad program of public social services. The physical and mental well-being of every person in the United States, its Territories, and possessions, is a concern of Government. A national health program must provide for the development and operation of social and health measures which must be related so as to assure continuity and integration of services. These must include preventive, diagnostic treatment, convalescent, and chronic aspects of care and aim at rehabilitation wherever possible.

Participation by the Federal Government and the States in the development and financing of a national health program is necessary to guarantee adequate and coordinated health and medical care of high quality, and general access to it. The consumers of health services should also participate in their development and financing through the channels of a comprehensive national contributory scheme of social insurance.

Facilities and services as well as benefits should be provided for all people in the United States as a matter of right, regardless of race, creed, citizenship, residence, and economic status.

With this general point of view in mind we examined S. 1456, S. 1581, S. 1679, and S. 1970 to see to what extent they meet the standards on service and coverage of medical care which we believe are necessary.

SERVICES AND COVERAGE

Our platform states that a comprehensive program should provide integrated health, medical, and social services of good quality to all people everywhere in the United States. These services should be readily available under conditions in which the dignity of the individual is fully respected. Included should be complete and continuous care, preventive, diagnostic, therapeutic, according to the individual's social, medical, and nursing needs for as long as required. Also, there should be provision for correlation of public health, medical, surgical, psychiatric, dental, and nursing services, including all specialties.

When we examined S. 1456 we found that one of its purposes is "to make high quality of hospital and medical care available to all persons in each State" (pt. A, sec. 701). This is in line with our criteria, but in section 702 "hospital and medical care" are defined as surgical, medical, diagnostic, and out-patient clinic services in a hospital up to 60 days a year. Also, this bill provides for the issuance of service cards of participating nonprofit prepayment plans for hospital and medical care to all persons who are certified by an appropriate agency as unable to pay all or part of the subscription charges of prepayment plans for such care. This bill fails to provide comprehensive care because preventive service is excluded from the plan; also it fails to provide for all people and covers only those who can prove need.

Many people still believe that voluntary plans can solve the problem of paying for medical care. Our experience with voluntary plans leads us to believe that they are inadequate to meet the problem. Most voluntary plans restrict their services, often not covering many illnesses or the full cost of needed medical care. The geographic limitations of these voluntary plans tend to limit the nature and scope of services in proportion to the income of the area. The actual record of voluntary plans in our country illustrates that although they perform a valuable service, they do not perform services of sufficient scope for enough people and for those who need the services most.

S. 1970 has as its purpose the subsidy of voluntary prepayment health services so as to make these generally available in the communities which they serve at charges based upon the income of the subscribers. We doubt that even with subsidy, a comprehensive plan which has to charge 3 percent of earnings will attract membership on the part of people who most need protection. Under the national health-insurance program the cost of care is shared by the employer and employees. In the case of the self-employed we are told that 2¼ percent will be approximately the premium.

When S. 1581 was reviewed we found that it carries this provision in section (b) (2) "States are to be aided in extending the provisions of medical, hospital, and dental services without discrimination to all individuals unable to pay the whole cost thereof." However, from the sums of money to be appropriated (pt. B, sec. 211) and from Senator Taft's own statements of the intentions of this legislation, it is apparent that only a small part of the population is to be aided.

Both S. 1456 and S. 1581 provide for a means test in order to determine eligibility for medical care. Social workers have probably had more experience with investigation to prove poverty than any other group in this country. We believe that it is demeaning to the individual. Also, it would serve as a deterrent to many families who would put off receiving medical care at a time when control of disease and/or prevention of disability are possible, or they would deny themselves necessities in order to keep from receiving medical charity and thus endanger their health.

We have found that a means test is hard to administer in giving basic maintenance to people—shelter, food, household necessities, clothes, etc. It seems to us that a means test would be much more difficult to carry out in the complicated problems of medical care. Medical needs are sporadic and medical costs unpredictable. Perhaps a specific situation will illustrate this problem. Here is a family with take-home pay of $6,300 a year. We would not expect a family with income way above the average to need help with medical care under ordinary circumstances. The husband makes $3,934 a year as a cost accountant on salary. The wife's annual income from her work as a technician is $2,366. There are three children, a girl 10, two boys, 8 and 6. Since the mother works, she has to pay for help in the home. The family has always carried hospital insurance.

Six months ago the husband developed a kidney condition and has been hospitalized three times during this period. He has had two serious operations. Bills have been received for medical and surgical services amounting to $1,000. The husband's salary stopped when he became ill, and this family of five has been attempting to live on the wife's take-home pay of $197 a month.

In this situation the family could meet ordinary medical needs and would probably be ineligible under a means test; however, we see that the costs of an extended and incapacitating illness in terms of medical bills and loss of income has precipitated an economic crisis in this family. In this instance, as in thousands of others, we see the need for preventing such a tragedy. In effect, S. 1456 and S. 1581, because they require a means test will only help the poorest group in our country.

S. 1679 would establish a system of prepaid personal health insurance on the principle of social insurance. This bill provides payment for complete medical services for employees, self-employed persons and the dependents of such persons. Also, State and local agencies may pay into the health insurance fund in behalf of others, including the needy. This bill enables all persons to receive the same quality of service.

S. 1679 offers opportunities to the families in middle-income brackets to pay for medical expenses while they are well and according to their incomes. Social workers know so well the situations of middle-income families who can meet their needs until sudden illness strikes. For example, here is a man who earns $3,045 take-home pay in a local Government position. His wife earns $1,433 as a teacher in a private school. They have a 6-year-old son. The wife was operated on for an intestinal obstruction and had to be hospitalized three times in a 4-month period. Her medical bills are as follows:

Hospital bill	$306
X-ray and laboratory services	45
Private nursing	720
Medication	21
Total	1,092

The family went in debt to pay these. The wife has not yet received a bill from her private physician and wonders how she will pay it. An additional expense has been $374 for a substitute at school, since she has been unable to work for a 4-month period. Unfortunately this family had no protection against these medical costs. If they had had voluntary hospital and health the annual premium would have been approximately $60 to $80 and would not have covered the largest item in this particular case, $720 for nursing, nor much of the physician's fees. Under national health insurance they would have had to pay no more than $72 a year for complete medical costs.

S. 1679 more nearly meets our standards of needed services and coverage than any other proposals. Also, it provides for self-help which our citizens prefer to medical charity or free care.

FINANCE

When we consider the financing of a program of health and medical care, we are committed to the following principles:

1. All basic public-health facilities and services should be financed by government alone.
2. National contributory social insurance coupled with some general funds from the Government should provide jointly for the capital investment involved in the urgent expansion of free, low and medium cost health centers and institutional facilities for diagnosis, treatment, rehabilitation, custodial care, and for research and professional education as related to the full development of the Nation's physical and mental health.
3. Grants-in-aid and loans for capital investment should be available for public and nonprofit private facilities of good standards.
4. National contributory social insurance coupled with some general funds from the Government should meet the operating cost of such facilities, if above their earnings derived from reasonable fees.
5. Reasonable fees for individual service—outside general preventive measures—should be covered by adequate benefits under a comprehensive social insurance scheme available to the insured and their dependents as a right.
6. Public funds, including those of social insurance should be administered by public agencies and disbursed to private agencies only for specific services ren-

dered to the insured. Voluntary private agencies should not be made disbursing agents of public funds.

7. Government and social insurance funds—outside those needed for statutory benefits and services—should be allocated under conditions which would permit government to equalize the burden of cost among the States and within them.

FACILITIES AND PERSONNEL

We subscribe to the other titles of S. 1679 providing for expansion of health facilities, education and training of health personnel, intensification of research, extension of public-health services including maternal and child-health care.

We approve especially of the provision for aid to rural and other shortage areas. This bill would encourage the development of group practice which we regard as a means of providing integrated and economical services. All those resources are essential to the successful operation of a comprehensive national health program. However, national health insurance is imperative to underwrite the costs of maintaining these expanded resources. In this way, only can we achieve our goal of maximum health and well-being for every American.

CONCLUSION

In view of the above testimony, we believe that our objective of making a full health program available to every citizen can be achieved largely through the national health insurance system proposed in S. 1679, and, therefore, we endorse the proposed purposes, principles and philosophy of this measure.

Senator **Murray**. That will conclude the hearings today, and we will meet again Monday morning at 10 o'clock.

(Whereupon, at 12:10 p. m., the subcommittee recessed until Monday, June 27, 1949, at 10 a. m.)

NATIONAL HEALTH PROGRAM OF 1949

MONDAY, JUNE 27, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, United States Capitol, Senator James E. Murray (chairman) presiding.

Present: Senators Murray, Taft, and Donnell.

Senator Murray. The hearing will come to order, please.

The first witness this morning is the distinguished chairman of this committee, Senator Thomas of Utah, who will testify on the education titles for the committee.

STATEMENT OF HON. ELBERT D. THOMAS, UNITED STATES SENATOR FROM THE STATE OF UTAH

Senator Thomas. Mr. Chairman, I appreciate your invitation to let me come and give you one idea that I have cherished for a long time in regard to our Government and the health services.

I appreciate, as chairman of the committee, the wonderful work which this subcommittee is doing, the seriousness with which it is undertaking what to me is one of the most important studies we have yet attempted, and the splendid manner in which you, Mr. Chairman, are carrying on with what we are attempting to do.

It is wholly in a spirit of helpfulness that I come before you. A witness is supposed to tell something about himself in order that it may be determined whether he can speak with authority or not. I cannot speak with authority on any subject. I have never been a deep specialist, but I have been a pretty good observer of things; and as far as health is concerned, I have gone through all of the agonies and all of the experiences of one who is a victim of the doctors.

Now, by this I do not mean that I have been ill-treated, but I knew personally the Surgeon General of the Japanese Army, who up until that time was recognized as probably the greatest innovator of ideas in regard to military health that the world had ever seen and who did the hitherto unheard-of thing of taking his men into war and bringing them back in the midst of Asiatic illnesses that we did not know much about, without much loss of life.

I have been quarantined; I have been through all sorts of epidemics; I have been caught on board ship and required to wait, not for hours for investigations and quarantine restrictions, but for days. I have seen oriental scourges at work, and I have lived through them. I know what laxity in regard to public health means.

Now, I also have had the privilege of traveling with a doctor who is a professor of public health. We journeyed through a number of Latin-American countries. While I was not interested in the things in which he was interested, I could not help but observe some of the problems facing them.

In the First World War we killed more boys getting them under the colors than were killed by German bullets. No one is at fault. I tried to overcome that situation, and I think we did overcome it in the first Selective Service Act, by requiring, before men were called to the colors, that there be housing for them, that there be equipment, that there be facilities, that there be properly trained officers.

It is of interest to point out here that the War Department and the commanding general and the Chief of Staff opposed that provision. They opposed it because they thought it might interfere with the Selective Service. They went so far as to have a special committee made up of the Chief of Staff, his assistants, and the man who was slated to be Director of the Selective Service—not with me personally, with Senator Sheppard—and asked that that provision be left out of the bill.

But these men had not been through the experiences of the First World War on an administrative side, and I had seen it all; and while, of course, it is always hard to express oneself in the presence of outstanding authority, the truth of the situation was so overwhelming that we insisted upon the provision remaining in the bill.

As soon as war was declared, immediately a committee from the War Department came and asked that that section be taken out. I protested again, and we kept it in. Now, that provision saved hundreds of boys' lives. The interesting thing, though, Mr. Chairman, and the point that I want to make is that in the last Selective Service Act the provision was left in, there was not a comment about it, the Army was not opposed, no one was opposed to it, and on the floor of the Senate no one asked any questions.

I point that out to you because those of us who have had to deal with legislation assumed to be impractical with respect to institutions sometimes have to pioneer our way, despite the experiences of administrative officers with whom we are dealing. We can point out other occasions.

For instance, I may refer to the provision in the Selective Service Act which provides that men shall be given their jobs back. That was declared unconstitutional by the former chairman of the Judiciary Committee when it was presented to him; but it is in, it has worked, it has brought happiness.

That was not brought there by a great lobby of American Legion or Veterans of Foreign Wars or people of that kind. That was brought there out of the experiences of a man who had observed. We may go on, one thing after another.

Now, in the wartime, both in the Second World War and in the First World War, I had much to do with the starting of nurse training. I know the resistance on the part of the medical schools and the schools in undertaking nurse training, nurse education.

This time I fathered the first WAC bill, the second WAC bill, the nurse-education bill, and had a lot to do with the hearings in regard to the drafting of nurses, only to find out that we had plenty of nurses in the service, but they were not properly distributed; and yet our Government was ready to reach in and take out of the hospitals and the civilian activities nurses in places where they were already understaffed.

The problem, therefore, is not just one of health. It is not just a problem of administration. It is a problem dealing with real statesmanship, it seems to me.

Now, if we do not take into consideration what we have faced in the last two wars and what we are facing now and build upon those experiences, then I do not think that we will be very successful in meeting the other one. I know that ultimately we will be successful, because that is the history of our country.

What I have come here to plead for is that consideration be given to a national service school. I know it will not be given. The opposition on the part of the medical schools is too great, too keen; the opposition on the part of the services—but, ultimately, it will come if we are going to take care of things.

West Point was not born overnight. When you go to West Point now or when you talk to a West Point graduate and you say, "Young man, there was had an awful hard struggle back in Jefferson's time getting this thing started," he will not believe you.

Nor will a man who stands in front of Boulder Dam believe that people could have been opposed to that. When they go over and look at our Constitution and our Declaration of Independence and you say that not all the people in America were in favor of either one, people look at you rather strangely. They cannot understand it.

Now, we have not only West Point, we have Annapolis, we have our service school for merchant marine, we have our service school for merchant defenses; but still we are lacking in what is most essential, as I see it, after having gone through the experiences, the most essential service school that the country needs. That is a service school which will provide doctors, dentists, laboratory technicians, nurses, various kinds of assistants, training up to the middle school or what we call now the lower division grade for people who want to go into the civil service and become assistants in hospitals, and so on.

Hospitals for what? The Army, Navy, Public Health Service. Technicians for what? Technicians for the various departments that are carrying on scientific studies constantly and dealing with health, public health—the Agriculture Department and those departments.

Our country is backward in not realizing that it has a right to train its own personnel right from the ground up. It ought to do so.

The mission of such a service school is not just the mission of a West Point or an Annapolis or a merchant marine school. It is very much bigger than that, because our country is faced with problems outside the problems of just health.

Harvard has a great medical school, but it cannot solve the race question in regard to that school. It cannot solve the sex question in regard to that school. It finds itself controlled by its own institutions and its own thinking, and when I say "Harvard," I may mention any other institution in the country. The University of Missouri Medical School, if it has one, or Washington University in St. Louis.

Senator DONNELL. It surely does have one and also Washington University.

Senator THOMAS. Thank goodness.

The point is that we have in our country, especially as it is related to health and the health services, a racial question, a religious question, and a sex question. No matter what any administrator of any medical school in the country may tell you, that school is not big enough to settle those questions or to go forward with them.

You will find that to be true if you get hold of the committees that advise the medical schools on going into examinations, examinations not to find out the best equipped, but examinations to eliminate, because there is such a demand for entrance now—you will find that those three problems are the biggest problems, and no school dares attempt to settle them.

The American Medical Association will not tackle the problem; none of the organizations which may be called lobbyists or self-preservation organizations, or whatever you call these things, will tackle that question.

In the whole southeastern part of the United States I believe there is only one dental school for 15 or 16 million people. There you have the black-and-white question.

We have out our way the Japanese question, the Chinese question, the Spanish question, the Mexican question, and all the rest of it.

If we are going to settle those things—and by "things" I mean the biggest questions we have to settle—they will have to be settled on a Federal level because the Government of the United States is the only institution big enough to tackle them.

Now, for 6 years I was an administrator of a medical school. I know the pressures. I have taken part in the efforts in my own State and I know in our own locality my school offers the greatest geographical potential for medicine, nurse training, training of that kind that there is in the United States.

Our school has always been intensely cosmopolitan. It has never had the questions I suggested before, because we have had Maoris from New Zealand and we have had Indians from western Canada and the rest of it. But when it comes to a medical school, you are up against a different proposition and you have all the pressures in the world. The only way the trained boy who finds himself—or the trained girl, because she is also proscribed against, no matter what anybody says, in our medical schools just because of the pressure of groups—there is the doctor pressure, there is the alumni pressure, there is every pressure in the world to see that the school remain the grand old institution it has always been and not allow other things to happen.

Now, some people are happy with the way things are going. I am not, because there are many worthy young men and young women being left out of consideration at this time. Now, the national service school will not only meet a great need, but the country stands ready for it because the country needs its graduates.

Our Veterans' Administration alone could supply a school, and the Veterans' Administration in times past has tried to have its own nurses schools, for example.

Now, we have brought about tremendous reforms in the veterans' organization in regard to veterans' hospitals, nurse supplies, doctor supplies, and all the rest of it. Everything is growing and going forward in a fine way.

The notions we had a little while ago that no veterans' hospital should be put near a medical center because a veteran might become a guinea pig or something of that sort—that notion has already gone and people are not afraid of it. But it was with us, and it was something that had to be combated. The people in the hospitals suffered as a consequence, and medicine did not make the advance it would have made had there been the chance for observation and consultation and the rest of it. We made that reform.

In the last war we made many reforms. But in this great health program that you are undertaking I can see no way of settling these big broad questions but for the Government to do it itself. By that I do not mean, Mr. Chairman, for the Government to get right out and establish a great medical school. In the first place, that would hurt the other medical schools, because there is not the faculty that you could use without hurting somebody.

That is not the way for anything to grow up. You have to grow on an experimental basis and a little at a time. But there will be no competition in starting lower division, premedicine, predentistry, prenurse, 1 year at a time, and give these people a chance and let the remainder of the educational institutions of the country see that probably somebody from a race that they do not like, somebody from a sex that they do not like, or somebody from anything else that they do not like, has not hurt the big school.

That is the only way you are going to convince people of these things. It should be done with great concern and great understanding.

Now, we have had experience with the Science Foundation bill, we know the pulls and the tugs and the rest of it. We read in the papers how corrupt the Federal Government is if it gives subsidies to a service, how corruptive its influence is.

The Federal Government in one single year gave the Massachusetts Institute of Technology $55,000,000, and I do not think it is any less independent than it ever was. It was not hurt.

In another year Columbia got $18,000,000, yet the President of Columbia said the other day that you must be careful about these evil influences of government.

Think of it. There is a man who since he left the public schools has had West Point training, has been in government all his life, and will be in government all his life, because by my own bill that man will remain in active service and receive full pay of a five-star general as long as he lives and can wear his uniform anywhere; but he is afraid of the Government of the United States and its influence upon some institutions.

Those are not loose statements. We know about the pressures in our country. We understand them.

I say that you will never settle them, you cannot get one more student into most of the medical schools now by subsidy. And think how you will corrupt those schools if we listen to what is being said, if you subsidize students there. But they are filled and they are running. So the national service school cannot hurt them.

Now, Mr. Chairman, I am not frightened of the way America is growing up. We will always have pressures, we will always have men who want to accomplish their objectives by using some fear slogan. We have lived through these things before, and we will live through them again; and your bill, Mr. Chairman, will not become law without having all sorts of things said about it and all sorts of things said about you. But the things that are said do not make them true, and we can live through them.

But I think for the Government of the United States not to be in a position to take care of its own interests in time of emergency—and the Government of the United States has never seen any other time but a time of emergency since it started, because it has been a growing organism and a developing thing—and there has always been opposition to everything it did. It does not matter when it happened. But I would like to see, if we get into another emergency or if we find ourselves in a great epidemic or if we find ourselves caught in one way or other wherein the statesmanship of this health bill becomes a savior of many people, I would like to see it written in such a way that it can take care of the interests, not only of the United States but of the people of the United States and the interests of each of the States and the people in them.

You all know my feelings about an American citizen: That every one of us has a dual citizenship, that we are citizens of the United States and citizens of the State, and we cannot do away with that relationship and we ought not to let our notions of federalism interfere with letting the citizen who is a citizen of the United States have the advantages which the United States has to offer.

There is no real conflict between those two citizenships. Utah has never tried to grab me and pull me and the Federal Government has never tried to grab me and pull me. In fact, I as a representative of my State—you cannot call me an official of the United States, I understand, constitutionally—but as a man on the United States pay roll, I have never found any conflict between the two and it is not there.

So, Mr. Chairman, may you succeeed in your wonderful work and may you give some moments over to the consideration of a national health service school, but I warn you if you do that, the dean of every medical college in the country will oppose what you are doing, and will say, "We don't want a West Point for medicine," and all that sort of thing.

That is not what is contemplated at all. I have been at this for several years, I have written deans and organizations and Presidents of the United States, and so on. They do not see the point, but that does not discourage me. It will come some day, Mr. Chairman, and I thank you for letting me appear.

Senator MURRAY. Senator, the legislation now pending before the committee contains provisions for aid to the existing schools and it also has a provision, as I understand, providing for a study of the long-range program.

Is it your idea that this proposal for a national service school should be part of the long-range study, or do you think that we should consider acting on it in the present legislation?

Senator THOMAS. I surely would not mix it in the emergency part of your bill. It has already been recommended for long-range study in the bill for the reorganization of the Army and the Navy, the bill that I reported out on the Senate floor.

There was the training feature, and the national service school would have grown in the Army and Navy, and I think that when our social-service departments begin thinking this thing through, they will find what a great unifier it is, bringing the Public Health, bringing the Surgeon General, bringing all the people into thinking the problem through in the big, because there is only one real Government of the United States, after all, in spite of the divisions between them and the contests that go on between the various branches of the Government.

I am sure that after thinking through the problem, the United States Public Health Service, the Surgeon General of the Army, the Surgeon General of the Navy, and the other medical directors of our country, the Surgeon General of the Veterans' Administration, that they will like the idea of thinking in terms of a team, taking care of the United States rather than the other thing.

It does not reduce competition; it does reduce duplication, of course. It makes all of the men interested in the health of the United States actively interested in the big basic problem.

Senaor MURRAY. Are there any questions? We are grateful for your views here this morning. I am sure we all recognize that you have had very valuable experience, Senator, and the statement you have made here this morning will, of course, be studied very carefully by our committee, and we certainly appreciate your appearance here this morning. I think you have made a very fine contribution.

Senator THOMAS. Thank you, Senator Murray.

Senator MURRAY. The next witness will be Robert A. Hornby, of San Francisco.

STATEMENT OF ROBERT A. HORNBY, APPEARING ON BEHALF OF THE COMMITTEE ON SOCIAL SECURITY OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. HORNBY. Mr. Chairman, there are, I believe, some 75 copies of the written testimony which have been supplied to the committee. I find some minor errors in the text. I would like very much to correct those and I have marked a corrected copy, which I would like to hand to you.

My name is Robert A. Hornby. The position for which I get paid is vice president of the Pacific Lighting Corp. of San Francisco. We happen to be in the public utility business in California. We serve all southern California with natural gas. We have some 7,700 employees.

Senator MURRAY. That is a natural-gas utility?

Mr. HORNBY. Yes.

Senator MURRAY. Where do you get your natural gas?

Mr. HORNBY. We get it from California and from the Permian Basin at the present time over in west Texas and southeast New Mexico.

I appear as a member of the Committee on Social Security of the Chamber of Commerce of the United States, which is a federation of more than 3,000 local, State, and regional chambers of commerce and trade associations. Those organizations have a membership of one and one-quarter million American businessmen.

My testimony will be concerned almost entirely with the issue of compulsory health insurance, as proposed in S. 1679, now before this subcommittee, and more particularly title VII of that bill.

THE CHAMBER'S BASIC POSITION

The Chamber of Commerce of the United States is keenly interested in fostering the good health of the American people. It has long engaged in efforts to this end. These efforts of ours antedate the current agitation for compulsory health insurance. In particular, the chamber for years has constantly aided and advised businessmen at the local level with respect to methods of improving health in their communities.

More recently, the chamber conducted in Cincinnati an all-day conference on community health progress. The primary purpose was to focus attention on what local communities have done, are doing, and can do, toward the Nation's health. I took part in that conference, and, incidentally, this booklet has just come off the press. Those entire proceedings are included in a booklet entitled "American Economic Security," dated June 1949, "Special Issue on Your Community and the Nation's Health Problems; Proceedings of Fourth National Conference on Social Security."

If the committee is interested, there are quite a few copies of that, and I am sure they can be furnished in whatever number your desire.

Senator MURRAY. May we have one filed for the record, and if you have extra copies which we may have, they will be distributed among the Senators on the committee.

Mr. HORNBY. We would be delighted to do that.

(The booklet referred to above will be found in the files of the committee.)

Mr. HORNBY. Through participation by an interested audience, and through distribution of the proceedings of the meeting, we hope that a significant contribution to health progress has been made.

The chamber's position on national issues comes into being by vote of our member organizations. Only last month those organizations in annual meeting here adopted a series of policies in the health field.

They said that tremendous strides had been made in general health improvement by voluntary methods; that there is no great crisis in the health field; that efforts to further improve health standards properly belong at the community level; that general public-health activities should be further encouraged; that voluntary nonoccupational prepayment insurance, which has made such rapid strides in recent years, should be encouraged; and that compulsory medical-care insurance should be opposed because it would operate to reduce present high standards of medical care to a uniform level of mediocrity.

On the basis of these policy declarations, the Chamber of Commerce of the United States opposes the compulsory health-insurance plan before you. We believe it would largely destroy the complex cooperative interrelationships among the many existing voluntary and governmental bodies now active in the health field. Yet it is this cooperative pattern which is mainly responsible for America's rapid health progress.

I will not seek to develop these general considerations further at this time. I know that you repeatedly have heard testimony presenting the broad general reasons for opposing a socialized-medicine law. Instead I will draw on my own experience, presenting facts, and their implications, which I know personally to be true.

I do so because my experience is typical of the considerations which motivate the members of the chamber of commerce to adopt policies such as the ones to which I have referred.

The subject of health insurance has long been of deep interest to me. For the past 19 years one of our subsidiary companies has had an extensive hospital- and medical-service plan. Recently we adopted hospital and medical plans of the reimbursement type for our other two companies. Prior to World War II, I had occasion to examine a large number of voluntary group plans then in effect in the United States.

HOSPITAL AND MEDICAL PLANS OF PACIFIC LIGHTING SYSTEM

Before the last war it had been the hope of the Pacific Lighting Corp. that we could develop a uniform plan for all three of our subsidiaries. They operate in the same area—southern California—use the same employment practices, apply the same wage scales, have almost identical working conditions, and produce and handle the same product—gas. After our study we decided that no one plan met the needs of each of the three groups of employees.

The hospital and medical plan which had been in operation for 19 years in one subsidiary had been closely supervised, had been funded jointly by the employer and the employees, and is the panel type of plan; that is, rendering service, rather than reimbursing the employee for his hospital and medical expenditures. It was not until late last year that satisfactory plans were evolved and instituted in the remaining two subsidiaries. In following the results of the company with the plan and the two without the plan, we have learned a great deal about how people behave when they are ill, or think they are ill, how to avoid abuses and control costs, and what is and is not accomplished by those plans.

When, as a delegate, I attended the National Health Assembly in Washington, D. C., in 1948, I spent my time in the medical-care section hoping that I would hear many examples of specific plans and what had been done to overcome their troubles. But most of those present had had no experience, and those who were speaking from experience had not reviewed their results critically.

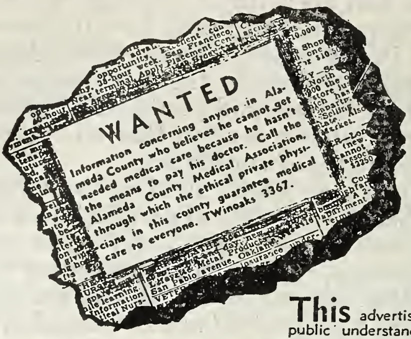
It had also been my expectation that there would be considerable factual material presented as to the health of the nation by areas, as to the health of this Nation in contrast with other nations, and particularly, as to how mass medicine was to produce generally good health. But I came away with a firming conviction that mass medicine will not produce good health.

GUARANTIES OF MEDICAL CARE IN CALIFORNIA

If other metropolitan areas are similar to those in California it could not be true that great numbers of peoples are suffering from ailments for which they are not receiving medical care. In this regard some rather interesting experiments have been conducted in Alameda, Santa Clara, and San Diego Counties in 1948 and 1949. Large advertisements have been run in daily newspapers stating that medical care is available, giving the name and telephone number of the county medical association and making certain recommendations as to joining voluntary plans and as to budgeting in advance for the cost of medical care. I would like to leave with the committee a set of those advertisements. Unhappily, I do not have many of them, but I do have a complete set. This happens to be those in San Diego County, and we have a set that ran in Alameda County. That is a complete set there. Then, there is a slightly different set we ran in Santa Clara County, despite the lack of illustrations and usual advertising agency methods to get attention, these that ran in this rather editorial type in Santa Clara County seem to have gotten the greatest reception. I would like to enter those in the record.

Senator MURRAY. Those will all be made a part of the record. It is necessary to reprint them, but they will be part of the record.

(The advertisements referred to are as follows:)



WANTED

Information concerning anyone in Alameda County who believes he cannot get needed medical care because he hasn't the means to pay his doctor. Call the Alameda County Medical Association, through which the ethical private physicians in this county guarantee medical care to everyone. TWinoaks 3367.

This advertisement is necessary to public understanding of modern medical economics. Some people honestly, but mistakenly, believe there are those who suffer without medical care* because they can't pay for it.

MEDICAL CARE* IS UNLIMITED

To the destitute

Your own private physicians are the doctors who treat the indigent sick at the county hospitals. They always have assumed this extensive responsibility, for which they accept no compensation.

To those of reduced means

for whom medical ethics requires that the physician reduce his fee so that the patient will not be deprived of the other necessities of life.

To everyone

because for more than 2000 years—since Hippocrates—no **ethical** physician ever has turned his back upon human suffering because he might not be paid.

WE RECOMMEND

A Family Doctor

Arrange, while you are well, to have a family doctor—one who will know you and be immediately available in an emergency.

Health Insurance

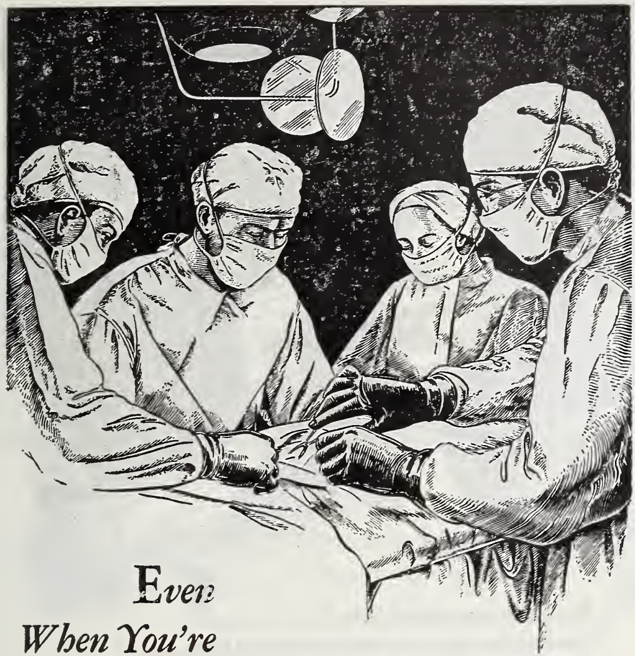
Arrange, while you are well, to cushion the economic shock of illness. Enroll **now** in one of the low-cost voluntary plans for health insurance.

Through Their BUREAU OF MEDICAL ECONOMICS
PHYSICIANS OF ALAMEDA COUNTY
UNCONDITIONALLY GUARANTEE
MEDICAL CARE* TO EVERYONE

* Medical care includes only the service rendered by the physician. Physicians have no control over the other costs of illness, such as those for hospitalization, nursing, drugs, appliances.

ALAMEDA COUNTY MEDICAL ASSOCIATION

364 14th Street, Oakland **TWinoaks 3367**



Even When You're Out of Money

For most things in this life, you need money—or you can't get them! You need money to buy a car, build a home or purchase food and clothing.

But there's one thing which you can always have—even when you're out of money. That is, the services of physicians and surgeons. For more than 2,000 years, doctors have considered it a privilege to give their best for the relief of human suffering regardless of a patient's ability to pay.

Right here in this county, physicians and surgeons actually compete for the privilege of serving, free, in hospitals, patients who cannot afford payment... and only outstanding men are accepted to give their services. In their private practices, outside of hospitals, they treat thousands of persons every day at a fee scaled down to the patient's circumstances.

Medical care for everyone is not a dream for the future... It has always been here.

And now you can protect yourself against the economic hazards of illness by moderate cost insurance.

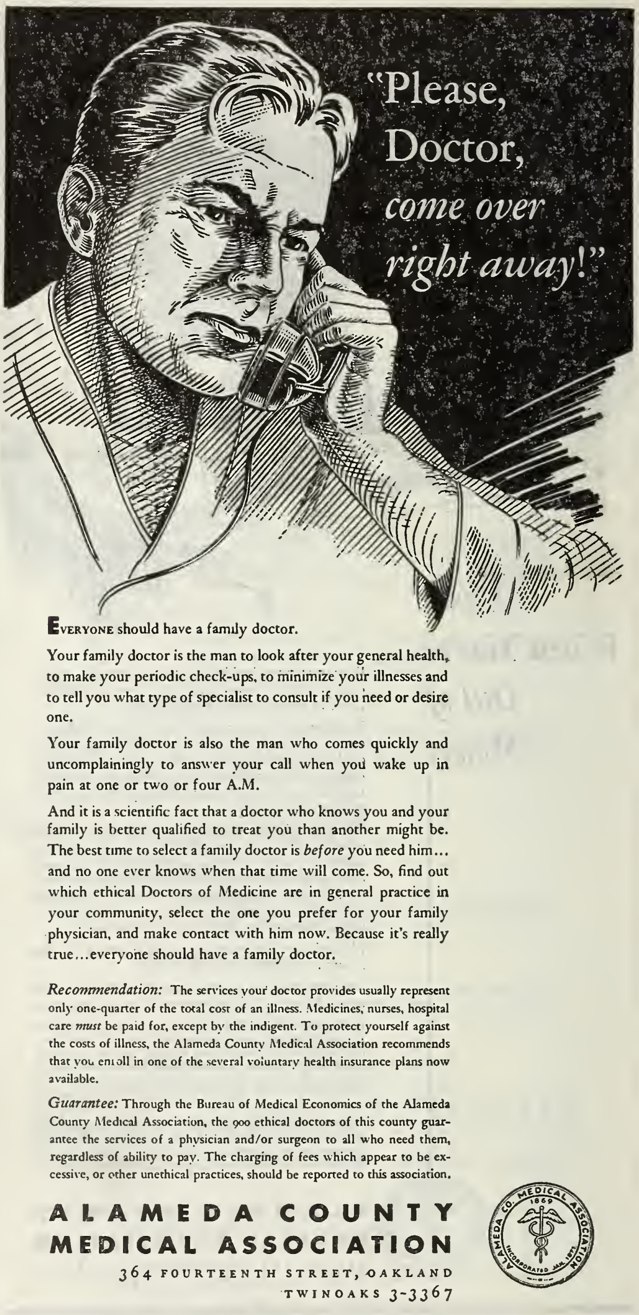
Recommendation: The services your doctor provides usually represent only one-quarter of the total cost of an illness. Medicines, nurses, hospital care *must* be paid for, except by the indigent. To protect yourself against the costs of illness, the Alameda County Medical Association recommends that you enroll in one of the several voluntary health insurance plans now available.

Guarantee: Through the Bureau of Medical Economics of the Alameda County Medical Association, the 900 ethical doctors of this county guarantee the services of a physician and/or surgeon to all who need them, regardless of ability to pay.

ALAMEDA COUNTY
MEDICAL ASSOCIATION
364 FOURTEENTH STREET, OAKLAND
TWINOAKS 3-3367

This advertisement will appear in Alameda County daily newspapers
February 2, 1948

Prepared by
EMIL REINHARDT *Advertising*
Oakland 12, California



Everyone should have a family doctor.

Your family doctor is the man to look after your general health, to make your periodic check-ups, to minimize your illnesses and to tell you what type of specialist to consult if you need or desire one.

Your family doctor is also the man who comes quickly and uncomplainingly to answer your call when you wake up in pain at one or two or four A.M.

And it is a scientific fact that a doctor who knows you and your family is better qualified to treat you than another might be. The best time to select a family doctor is *before* you need him... and no one ever knows when that time will come. So, find out which ethical Doctors of Medicine are in general practice in your community, select the one you prefer for your family physician, and make contact with him now. Because it's really true...everyone should have a family doctor.

Recommendation: The services your doctor provides usually represent only one-quarter of the total cost of an illness. Medicines, nurses, hospital care *must* be paid for, except by the indigent. To protect yourself against the costs of illness, the Alameda County Medical Association recommends that you enroll in one of the several voluntary health insurance plans now available.

Guarantee: Through the Bureau of Medical Economics of the Alameda County Medical Association, the 900 ethical doctors of this county guarantee the services of a physician and/or surgeon to all who need them, regardless of ability to pay. The charging of fees which appear to be excessive, or other unethical practices, should be reported to this association.

**ALAMEDA COUNTY
MEDICAL ASSOCIATION**
364 FOURTEENTH STREET, OAKLAND
TWINOAKS 3-3367

This advertisement will appear in Alameda County daily newspapers
March 15, 1948

Prepared by
EMIL REINHARDT *Advertising*
Oakland 12, California

ING M.D.
sician & Surgeon

One Door That's Always Open Regardless of Ability to Pay

. . . OFTENTIMES the assistance of a physician or surgeon means life itself. For this reason ethical doctors for 2,000 years have accepted, as part of their professional duty, the responsibility of providing medical care for everyone who needs it.

Daily, the doctors of this community treat hundreds of persons at fees scaled down to meet the patient's circumstances. Daily, members of the medical profession treat the needy in hospitals and clinics without charge.

Medical care for everyone is not something for the future . . . it's here . . . is has *always* been here . . . the doctor's door is always open . . . regardless of your ability to pay.

In fairness then, select your doctor in advance of need and arrange with him to serve your family. You will save his time and you will have help quickly when you need it.

If You Need Medical Care, *Ask for it!*

THROUGH the Bureau of Medical Economics of the Alameda County Medical Association, the 900 ethical doctors of this county guarantee the services of a physician and/or surgeon to all who need them, regardless of ability to pay. The charging of fees which appear to be excessive should be reported to this Association.

Recommendation

THE SERVICES your doctor provides usually represent only one-quarter of the total cost of an illness. Medicines, nurses, hospital care *must* be paid for, except by the indigent. To protect yourself against the costs of illness, the Alameda County Medical Association recommends that you enroll in one of the several voluntary health insurance plans now available.

ALAMEDA COUNTY MEDICAL ASSOCIATION
364 FOURTEENTH STREET, OAKLAND • TWINOAKS 3-3367

MEDICAL CARE HIGH LIGHTS

HOW 52,000,000 AMERICANS CAST A VOTE FOR A GOOD IDEA

One of the most progressive stories in the history of this country is that of the recent growth of voluntary prepaid medical-care plans.

The whole idea is one that grew out of some sound local planning by a group of physicians in a logging camp in Oregon some 20 years ago. By 1930, the idea had spread to 11 other areas. Soon, doctor groups originated prepaid hospital-care insurance plans; medical societies financially backed other plans offering even more extensive services. Public acceptance and physicians' support later led the American Medical Association, in 1942, to establish a special department devoted exclusively to aiding all persons or groups in expanding this democratic principle of voluntary health insurance for all Americans.

Today, 52,000,000 persons in this country are protected by some form of health insurance, 32,000,000 have Blue Cross hospital and surgery insurance; 11,000,000 more have surgical cost insurance. Another 9,000,000 have coverage for home and office care as well as hospital and surgical expense.

More than 25,000,000 of those enrolled have joined these plans in just the last 5 years.

To work diligently, through local medical societies, to test, develop, and encourage progressive medical-care programs has long been a prime objective of the American Medical Association. It helps to assure "the best there is" for all.

Service for all

If you know of anyone going without a physician's care simply because of financial reasons—please call our Medical Society office at once. The medical profession of this country, in keeping with its individual member's oath always to place the patient's welfare above every other consideration, guarantees that anyone needing the service of a doctor can get that service irrespective of the patient's ability to pay.

Protection for all

Any professional act believed to be contrary to public interest or the charging of a fee believed by the patient to be excessive, should be reported in writing to the society. The services of the Medical Society's ethical conduct committee are available to all.

Recommendations for all

Suggestion No. 1. Learn the day and night telephone number of your family physician—or the number of your local physicians' emergency telephone exchange. The latter is a phone service "that never sleeps." It can locate a doctor for you at any hour of the day or night. Suggestion No. 2. Arrange while you are well to meet the costs of hospital or medical care through some prepaid budget plan. Enroll in the voluntary health-insurance plan of your own choice, now. *Free information folders describing voluntary plans supplied upon request.—Santa Clara County Medical Society.*

(One of a series of advertisements being placed by the Santa Clara County Medical Society, San Jose, Calif. The above advertisement appeared during the week of April 18, 1949, in the following California newspapers: Mercury-Herald, San Jose; Evening News, San Jose; Dispatch, Gilroy; Times, Palo Alto; Register, Mountain View; Press, Campbell; Mail News, Los Gatos; Times, Los Gatos; Times, Morgan Hill; Standard, Sunnyvale.

MEDICAL CARE HIGH LIGHTS

"* * * INTO WHATEVER HOUSES I ENTER I WILL GO FOR THE ADVANTAGES OF THE SICK * * *"—OATH OF HIPPOCRATES

Hundreds of years ago, the great Greek physician and teacher, Hippocrates, father of medicine, wrote for his scholars the solemn oath that bears his name. On the wording of that simple creed—the full content of which you will find in any encyclopedia—is based your own doctor's code of ethics. The passing of centuries has not dulled by one whit the stern standards imposed upon the physician by the text of the Hippocratic oath. Today, as 2,000 years ago, he is dedicated to a life of service to his fellowman.

Left to its own devices, and entirely without political influence, medical science has striven constantly to help mankind overcome his ills and handicaps. Most of the miracles of modern medicine have come about, not through Government subsidy, but through private funds and free and unhampered enterprise. The results are everywhere evident. The American people of this era enjoy the highest health level * * * the finest standards of scientific medical care * * * the most modern medical institutions of learning * * * of any major country in the world. During the past 10 years, maternal mortality in America has dropped 63 percent * * * infant mortality has decreased 40 percent * * * and 6½ years have been added to the average life expectancy of adults. Such records speak for themselves.

Because it is part of the American method of doing things, Americans prefer to pay their own way—for medical service rendered, as well as for the other necessities of life. And to help them be prepared, in advance, for the financial problem of illness and surgery, doctor groups themselves long ago originated prepaid hospital care insurance plans. More extensive protection was soon offered by insurance companies and other independent organizations. As of this year, a total of approximately 52,000,000 Americans are now protected by some form of voluntary health insurance.

Service for all

Even so, for those unable to pay for medical attention, the physicians of this community would see that they had all needed health care without charge. If you know of anyone going without a physician's care simply because of financial reasons, please call our Medical Society office immediately. Individual medical care, regardless of ability to pay, is not a new thing. It is ancient as your doctor's oath of Hippocrates—as centuries old as medicine itself.

Protection for all

Any professional act believed to be contrary to public interest, or the charging of a fee believed by the patient to be excessive, should be reported in writing to the medical society. The services of the society's ethical conduct committee, for the unbiased review of such reports, are available to all.

Suggestions for all

Arrange while you are well to meet the costs of hospital or medical care through a voluntary health insurance plan. Enroll now in the prepaid budget plan of your own choice. Free information folders describing voluntary plans supplied upon request.—*Santa Clara County Medical Society.*

(One of a series of advertisements being placed by the Santa Clara County Medical Society, San Jose, Calif. The above advertisement appeared during the week of May 30, 1949, in the following California newspapers: San Jose Mercury-Herald, San Jose Evening News, and Palo Alto Times.)

Mr. HORNBY. About 15 replies were received to the first advertisement in Alameda County where the population is approximately 730,500. Of these 15 replies, there was only one bona fide case. The remaining replies were from cranks.

However, the county medical society has its own medical social consultant, who investigates any case reported and refers the individual to one of the numerous places where medical service is provided. The consultant likewise handles complaints to the county medical association, which, if they are not adjusted between the physician and the patient, are reviewed by a committee. The number of these cases is small.

The Alameda County Medical Association states:

> The objective toward which all efforts of the Alameda County Medical Association is directed is to insure the availability of services of physicians and surgeons to all persons in the area in which its members practice. The systems and organization employed are designed to be flexible, with as little red tape as possible. There is no guaranty that everyone will obtain medical care, but it is available to everyone who wants it.

The executive secretary of the San Diego Medical Society says:

> As a result of these ads running over a 3-month period, we received not over 10 inquiries from citizens who did not need medical care at the time, but wished to know of the facilities for future reference. It is extremely important to note that the San Diego County Medical Society did not learn of a single instance in which anyone was doing without medical care due to lack of funds.

The population of this county is about 560,000 at present.

The executive secretary of the Santa Clara Medical Society says:

> It was not without some fear of a possible avalanche of requests coming in if we ran a newspaper advertisement proclaiming this guaranty, but on April 18, 1949, nevertheless, the first advertisement appeared. Nothing like the estimated "tens of thousands" medically uncared-for persons appeared on the scene. We have since run a second advertisement, and to date we have received a total of only 14 requests. Seven of those have been taken care of in the following manner: Four were referred direct to physicians and have received care; one was referred to the county hospital and received care; one was entitled to care under county-hospital provisions in San Joaquin County (where the man was a resident); and the seventh was given care under the provisions of the Crippled Children's Act. The other seven inquiries which we received did not call for physicians' services under the terms of the guaranty, but were from persons making inquiry as to whether they could secure physicians' services on an open credit account. One inquiry was from a lady asking if we could have a doctor call on a neighbor of hers who did not want to receive the services of any physician, but the lady believed those services were required.
>
> We should like to point out that prior to the appearance of the first advertisement an exact printed copy was mailed to each member of this medical society, together with a postcard ballot and request for favorable or unfavorable comments. Sixty percent of the actively practicing members voted 125 to 4 in favor of the advertising program. One hundred and six (against 25) voted to have the society issue this guaranty of medical care for those who needed it. One hundred and eleven voted "Yes" (against 9 votes of "no") to the proposal to publicize the society's desire to be informed of anyone having been charged a fee that they believed was excessive. We mention these tabulations to indicate that this program in this country is not a propaganda device concocted by a small committee and activated by the officers of the society, but is, on the other hand, a sincere and continuing program which has the wholehearted support of practically all of our members.

There are an estimated 290,000 persons in Santa Clara County.

If it were true that large numbers of citizens are suffering or dying from lack of medical care, it seems almost certain that there would have been many responses to these advertisements, and that the advertisements would have prompted a furore among the citizens of these populous counties.

ARE COMPULSORY HOSPITAL AND MEDICAL PLANS HEALTH INSURANCE?

The popular selling term today for prepaid sickness care is "health insurance." However, none of the compulsory plans which I have seen qualify on either of the words. They do not provide good health nor are they insurance.

Health comes from such things as public sanitation, personal hygiene, balanced diet, good housing, adequate clothing, prudent exercise, proper working conditions, and good personal habits. A little self-discipline might be included. I realize that those who believe that someone in a Government job should watch over each of us from womb to tomb will reject self-discipline and self-control as being antisocial. Nevertheless, I am sufficiently old-fashioned to value them.

Insurance carries the basic concept that large numbers of people by banding together can spread their risks, lower per capita costs, and have adequate protection if a possible but not probable catastrophe overtakes them. But, when you are thinking of complete medication and surgery for everything from the sniffles to a panhysteroctomy, you should realize that the incidence of use will increase to the point where the insurance concept diminishes to insignificance.

In reviewing many insurance-company hospital and medical plans, and similar self-administered industrial benefit plans, I find that what is really being offered is the budgeting of almost certain medical and hospital expenses for those who elect to band together for that purpose. Those who are hawking Government health insurance administered by Government personnel are actually talking about mass medicine funded through taxation.

Persons supporting hospitalization, surgery, and medicine financed at the point of the tax gun usually talk about the financial ruin of the individual. In the few instances where they offer examples, they cite cases of individuals who have had illnesses or accidents that have run into thousands of dollars for hospital, surgery, and medicine. However, when they get down to designing their plans, they talk about everyday illnesses, as they realize only such a plan can be sold.

Thus they speak about the financial ruin of individuals, but call for compulsory medicine for daily illnesses. If catastrophe insurance is really what is needed, it could be provided at nominal cost. But the individual would have to assume the first $300 or $500 of the costs of any illness. Insurance of this sort certainly could be afforded by the overwhelming majority of working people in the United States.

The majority should be interested in obtaining coverage in accordance with their own ideas of what they need. American employees should recognize that a major source of revenue for any Government medical scheme is a tax on pay rolls and that such a scheme in all probability will not provide the type of prepaid budgeting for ordinary medical care, or insurance for catastrophe losses, which they may desire. The revenues will in large part be dissipated for the total or partial care of indigent patients. If the American worker wishes to pay for this, then the costs should be properly identified and not mixed in with the financing of his own coverage. Nor should he be compelled to take the type of hospital and medical coverage which someone in a Government job decides he should have.

Recently, before we inaugurated the hospital and medical plans in our largest subsidiary, we asked each association and union active in the company to appoint a representative to serve on a study committee. After several weeks of reviewing various insurance and service-type plans, the group selected a reimbursement plan.

During this period of investigation they learned the actuarial facts of life as well as the possible forms of benefit. They learned that you pay for what you want and that when a benefit "gimmick" does not cost much it probably is not worth much. They learned that coverage for females is expensive, particularly where the "little woman's" desire for attention exceeds her desire to attend her housewifely duties. They also learned that Junior can be an expensive addition where mother enjoys her medicine. They discovered that single-person rates are loaded where maternity benefits are part of the general plan, and that the single men do not care to subsidize the Nation's offspring, at least through this device.

They concluded that some self-imposed controls were essential if the costs were not to become unbearable. Some of them decided they would rather pay for their minor illnesses and buy insurance for the possible once-in-a-lifetime or maybe-never severe illness or accident. The committee was urged to tell the employees as a whole just what the plan did do and no more. They readily followed this advice. There is now slightly over 84 percent participation. It probably will not go much higher. Those who remain out of the plan have done so at their own election.

It is interesting to find out some of those who have remained out of the plan. I might first add that all of the department heads and executives, with no known exceptions, joined, except for those where there are some religious difficulties. Those who are out of the plan seem to be down-the-line employees, and we were curious to know why they did not join.

We found some of them were already members of Blue Cross and Blue Shield and they preferred to stay on in that plan for the reason that when they left the employ of the company they could go on participating in that plan wherever they might be.

The other group who stayed out were those who believed in faith healing and who under no circumstances wanted any part of any medical plan. And then there were some who just did not want any part. They preferred to go their own way.

In fact, one of them told me in my own office that he had Blue Cross, but he did not belong to Blue Shield and he felt that Blue Cross took care of his hospital; and, so far as the doctor's bill is concerned, he thought he could stand the doctor off if he did not have the money to pay him right away.

A similar but more blunt procedure was followed shortly thereafter in starting a reimbursement plan in the third company. In this case a statement was added as to what the plan did not cover. The insurance company had tremors over that one. We kept them off the premises, incidentally, while the plan was being reviewed by the employees. We got a very low interest at first. I think we did not get more than 35 or 40 percent. The insurance-company salesmen were not permitted to solicit. About 60 percent of the eligibles responded at first. This gradually increased to the point where the prescribed minimum of 75 percent participation was reached. Applications were then taken and the coverage made effective. The percentage of participation is now about 85 percent, but is not expected to go higher. Most supervisors and executives have joined, although some of them would prefer medical catastrophe insurance. Thus it is expected that the future will not be filled with disappointed or irate participants applying for reimbursement for noncovered conditions.

This intellectually honest and realistic sales approach is commended to those who would have us hospitalized and medicated under the aegis of a Government bureau.

TROUBLE IS THE ONLY COMMON CONDITION FOUND IN HOSPITAL AND MEDICAL PLANS

Our 18-month study of voluntary medical plans which we conducted prior to Warld War II showed that there were many variations in the types of plans, but they all had one common feature—trouble. Therefore, if emphasize trouble, it is because the record indicates the need for it. Social "lifteruppers" push aside these troubles as concomitants of any plan and necessary for the greater good. They particularly push them aside in the early days of a plan because they are so enthusiastic about getting the plan under way, especially where they may visualize themselves in charge of the particular Government trough into which they hope our taxes will flow.

It is essential to the soundness and particularly to the survival of any hospital and medical plan that the troubles be recognized and dealt with early. It is the abuses of plans which make them unduly costly and get them into disrepute, especially with those individuals of the highest personal rectitude. It is these people who usually represent the largest dollar volume of support and who, through their decency and self-control, make it possible for others to use the plan. Troubles in industrial plans can be minimized, but it takes intellectual honesty in presentation, tight controls on cost, everlasting vigilance as to abuses, and frequent reminders to the employees that abuses spell more cost to them.

In the early days of our service plan, when physicians learned that surgery would be paid for, it appeared that they preferred surgical methods to others. It was also evident that employees did not resist the surgery but, in fact, seemed to enjoy it. The first administrator of the plan encouraged healthy employees to "get in there and get some." He also learned that employees enjoyed purchasing medicine and he made some ingenous arrangements in this regard. Thus, the plan got a vigorous start, but the fund quickly developed anemia.

The administrator was removed and replaced with a man of integrity and high I. Q. However, the fund had to be resuscitated with the gold treatment. Doctors were selected who were willing to forego the experiences and fees of "freewheeling" surgery. They were made to understand that they had to engage in preventive medicine. The chief surgeon, and others interested in administration, decided they had to talk plainly to the hypochrondiacs. Miss Belle Acher was told that all reasonable diagnoses and cures had been employed, and that if she wished attention and medication for its sake, it would not be from the plan henceforth. The employees' executive committee now every effectively handles such cases.

THE BENEFITS DETERMINE THE CONTRIBUTIONS

The voluntary plan geared to the particular needs of the particular group permits the clear identification of the effect of use of the plan on the cost to the individual. If he misuses the plan he soon feels the pressure on his pocketbook nerve. On the other hand, lead him to believe the pressure will not be on his pocketbook nerve, and he promptly commences to devise ways to get all he can.

The members of hospital and medical plans expect high-type surgery, modern hospital facilities, and solicitous attention. These conditions necessairly creates high costs, and where the monthly contribution does not recognize these facts, then the employee should be made to understand that his benefits necessarily must be curtailed.

Too often medical plans have been designed from the viewpoint of the monthly employee contribution rather than from that of the medical costs. This is probably explained by the fact that employees seem readily to accept the insurance viewpoint when they are thinking of what they are willing to pay, but quickly switch to the value-received viewpoint when they become participants.

Recently when employees of our second subsidiary were being educated in what to look for in prepaid medical plans, they seemed to have the ingenious view that they could get complete coverage for $1.75 per month. It was only by handing to the employees the records of previous plans and by summoning representatives of Blue Cross, Ross Loos—incidentally, Ross Loos is peculiar to the Los Angeles area, a widely used clinical service—and several insurance plans before the group, and interrogating these representatives in detail, that we were able to convince the employees they would get precisely what they paid for—or—better, the kind of attention which they wanted must be paid for.

A plan which has a generous schedule of surgical fees, permits long stays in the hospital, covers laboratory charges, ambulance where needed, and an extra coverage for accident cases will run about $3.40 per month for a single person and $7.85 per month for an adult with two or more dependents. There has now been sufficient experience with such plans on which to compute costs for the various items of coverage within known upper and lower limits. The ultimate long-term cost depends on the insurance carrier selected, but, more important, upon the employees' and employers' subsequent efforts at control. Thus, where use and cost can be kept in relation to each other, actuaries can foretell within reasonable limits what will be the costs to us of prepaying our primary or our excess medical costs. There is no reason why we should delude ourselves here.

Those who dream up the rates of contributions for Government mass medicine seem to be depending on coincidence and clairvoyants rather than experience and actuaries for their cost predictions.

ECONOMIC GAINS ARE HYPOTHETICAL

In the January 15, 1947, California Senate Journal, the interim committee on prepayment of medical and hospital care made its report. The following quotation from it is illustrative of claims which have been widely made by groups proposing Government medicine:

> If a method could be found to more equitably distribute medical care to all the people and to fully apply existing medical knowledge and advanced public-health techniques to the general problem of medical care, there would be among the people of this State:
>
> (*a*) A lower mortality and morbidity rate.
> (*b*) Fewer severe illnesses.
> (*c*) Fewer early deaths due to preventable or ameliorable illness.
> (*d*) Less absenteeism from work and school.
> (*e*) A lower rate of rejections for military service among our young men.
> (*f*) Generally better health for children and adults.
> (*g*) And, ultimately, the large losses to the State's economic well-being would be considerably lessened.

These sweeping claims as to the results of mass medicine have, as I say, often appeared in similar form in the statements of those who propose hospital and medical care through legislation to be supervised and dispensed either by Federal or State Government. I have reviewed these claims in the light of the experience in our subsidiary companies.

(*a*) A lower mortality and morbidity rate (or fewer early deaths and less absenteeism): We have had an excellent check on the mortality of the working staff through a group life-insurance plan which has been in effect for 17 years. The records of time off for sickness are likewise complete, and the production per employee is well known.

The mortality anticipated in the group life insurance rates is probably greater than would be experienced in our industry. The actual mortality has been running much less than that anticipated in the group life insurance rates, at least for those employees below the department head level. The mortality for department heads and executives likewise has been lower than the expectancies, but some recent deaths may indicate that we have been "creating the mortality tables" for this latter group.

The bulk of the employees have very favorable working conditions; many of them work out of doors. The work loads are moderate to light, and the occupational hazards are minor where they exist at all. As the organization gets older, the diseases of old age may have an increasing effect. An annual general examination is available to those who carry the responsibilities of the direction and supervision of the business and who have or are likely to incur the disabilities of tension, prevalent among supervisory and executive positions. This involves various tests and C-rays designed to reveal heart strain, ulcers, mental fatigue, and similar conditions which may bring early disabilities or death. There has been some preventive medicine in these cases, but four recent sudden deaths have cast some doubt on the efficacy of this approach. In any event there has been no valid difference in the over-all mortality between the company with the hospital and medical plan and the companies without plans.

Time off for sickness has fluctuated both for and against the company with the hospital and medical plan. In 1948 the hours off for sickness in the company without the hospital and medical plan were 2.6 percent of the total exposed hours. For the company with the plan it was 1.8 percent. This might be used as evidence of the economic worth of mass medicine, but in previous years there was a reverse of this condition. In any event the presence of a hospital and medical plan does not seem to be the principal factor in lost time off for illness.

I had a very interesting experience as an officer in the Second World War when I had to shoot some trouble with the civilian personnel. We had some 27,000 civil-service personnel and were having some trouble in our command. One of the early notices which one of my officers brought back from a bulletin board was a typewritten sheet which said:

> The following civilian employees will take their sick leave in the following manner.

Apparently, it was running over the buckets, and some of them had alerted the officer that they were going to take it.

So I say that time off for illness when the days are available with pay is much more important than the time off when they seem to be actually ill.

Company working conditions provide 3 days off with pay for sickness after an employee has been with the company for 6 months, and this is increased to 60 days after an employee has been in the company for 10 years. The records show there is a marked increase in the number of days absent for illness after the employees have been with the company for 6 months. This grows with the number of days available. It might be concluded that employees drag themselves to work when they do not have available days off with pay. Whereas this might be true of those in supervisory positions, and the zealous worker, a check shows that days off for bona fide illness do not coincide with the total days absent for which the reason of illness is given. This experience is not unique with these companies but is rather general with those on government as well as taxpayers' pay rolls.

Thus it must be concluded that the lowering of mortality and the diminution of incapacity because of illness are not the assured results of prepaid medicine financed either by voluntary contributions or by taxes.

(*b*) Fewer severe illnesses: Our companies have a disability plan which picks up after 60 days and will carry the employee for a minimum of 5 years and a maximum of his prospective working life if he has had 10 years of service at the time of his disability. There is no discernible difference between the companies in the matter of long-term illness. However, it is likely that in all of our companies some illnesses have been avoided by early medical attention, probably where there has been both time and facilities for proper diagnosis.

The chief surgeon of the company with the hospital and medical plan stresses sound diagnosis as the principal weapon for possible prevention of long-time illness rather than the ladling out of medicine or the performance of surgery after the condition has become severe. It appears that in those countries where there is government mass medicine there is seldom time for complete diagnosis even where there is an inclination favoring such diagnoses. There seem to be many patients asking for much attention too often. Doctors are overwhelmed and soon learn that too large a portion of their patients have minor dispositions or are hypochondriacs. On the other hand, at the start of many severe illnesses there are sniffles. Because of the volume of patients which must be seen, the experience in countries who have government medicine is that sniffles are treated as the secondary evidence of a cold and not as the possible forerunner of a serious illness.

Thus it appears that any program to minimize potentially severe illnesses must be based on early and complete diagnosis and must be compulsory. This is a grade A paradox even in a regimented nation and an enigma in this United States. In the former countries there is not time (nor interest) for complete diagnosis. In the United States we will not submit to such compulsion—at least up to now.

(*c*) Fewer early deaths due to preventable or ameliorable illness: This has been covered in (*a*) and (*b*) above.

(*d*) Less absenteeism from work and school: This has been covered in (*a*) above.

(*e*) A lower rate of rejections for military service among our young man. At the time the California senate committee reached this conclusion, those who were urging Government mass medicine were glibly supporting their contentions by an analysis of the draft rejections. In some instances they concluded that 50 percent of the young men of the Nation were in such dreadful health that they were rejected for military service. There is no need to dwell on this statistical jugglery. There have been more recent analyses of the draft rejections which show that the conclusion about the bad health of the young men of this country cannot be supported by the statistics nor by the actual health of the young men examined.

The 50 percent conclusion was evidently adopted out of hand because the maximum seems to have been about 37 percent actually rejected of all those examined. The bulk of those rejected as unfit for military duty were, of course, perfectly acceptable and sound for civilian work.

There were possibly 6 or 7 percent of the total examined who might have been made available for military service if they previously had medical attention following a sound diagnosis. One of the causes for rejection was venereal diseases. There is much doubt as to whether mass medicine will prevent venereal diseases. But there is considerable evidence that education can do a job in this area.

I might say that I was well aware of the medical rejections in the Army Air Forces, where we had very high standards of physical condition. I must say that the young men we rejected for medical purposes in the Army Air Forces were not only perfectly capable of going back to civilian life and performing a good day's work, but many were subsequently reexamined and drafted into other branches of the military service.

Senator MURRAY. A lot of those who were examined and accepted were subsequently rejected by the Army after they had had them for some little time; is not that true?

Mr. HORNBY. In the Army Air Forces?

Senator MURRAY. Yes.

Mr. HORNBY. Not necessarily for medical. There are always some who go out subsequently for medical reasons, but not in the Army Air Forces.

Senator MURRAY. My understanding is in the Selective Service they found they were rejecting so many on account of health conditions that they decided to relax a little and accept them and try to improve their health after they got them in. They were compelled, as I understand the reports, to reject a great many of them afterward.

Mr. HORNBY. I will say this, sir—and this is subject to statistical proof—I think you will find that quite a few of the subsequent rejections were of those who were suffering from what was generously called nervous diseases, very often mental disturbances, men who turned out to be emotionally unstable.

Also, of course, you always discover illnesses that were incipient, and despite the best kind of physical examination, they subsequently turned up. That is particularly true of incipient cancer and tuberculosis.

I saw what was described in the Army as culls, a shipment of culls. They had been screened and rescreened. They were largely those of low mental capacity and I had occasion to go up and down the line and interview these young people who had been shipped to us, and we were attempting to find some conceivable good use for them.

Some of those people should never have been brought into the Army. I can say that the bulk of those 115 or 116 were largely people who had a bare amount of marbles to get by in this life and were either that or worse.

I also saw a young man who had four teeth in his mouth and I asked him how they let him by. He came from Brooklyn. But the bulk of them were from Arkansas and the southeastern area. They were certainly a sad-looking lot. But they were the result of some four or five screenings, of rejections from post after post, and we finally won them and were trying to find some possible use for them on our post.

We had to finally ship them out again because too many of them walked out on the flight line and got in the road of props and got themselves rather severely damaged.

(*f*) Generally better health for children and adults: Public sanitation, personal hygiene, balanced diet, good housing, adequate clothing, prudent exercise, proper working conditions, good personal habits, and perhaps a few other things are the foundation of what is known as good health. Children who are blessed with parents of rectitude, affection, and industry are likely to enjoy good mental health and good physical guidance. Doctors can make recommendations as to cleanliness, diet, clothing, exercise, and perhaps personal habits, if the doctor has time when he is treating an illness. They cannot inject a higher I. Q., more consideration or greater enterprise into parents. However, in general, hospitalization and medication are for the treatment of bad health, and certainly Government mass medicine will not provide the requisites mentioned for good health.

(*g*) The large losses to the State's economic well-being would be considerably lessened. The production per employee has been better in the company without the hospital and medical plan than in the one with the plan. We have learned that the day's production depends upon how well we lay out our practices, processes, work surroundings, and job standards, and how well we train employees. Also important is the "carrot and the stick." Employees must have the element of reward for good production held in front of them, and to the rear there must be the application of discipline or even the threat of job loss when they fail through the lack of desire or effort. All of us respond to the carrot and the stick. It is only after determining what constitutes a full day's work and holding people to this that we can hope to improve the volume of useful goods and services in this country. Economic losses in this area are far greater than the loss of production caused by illness.

If we are concerned about the demands upon the national economy, then the amount of additional goods and services which would have to be produced to pay for the lost motion, the abuses of benefits, the time lost in doctors' waiting rooms, and the always-exorbitant costs of doing anything through Government functionaries add up to be an economic demand upon the producing part of the population far beyond anything we have heretofore saddled upon ourselves.

UNPREDICTABLY HIGH COSTS

Sir Stafford Cripps recently demanded an extra $880,000,000 in Britain's budget. He said that the excess costs for socialized medicine alone would run $230,000,000 over previous estimates. The original estimate for free dental service was set at $28,000,000 but now is running in the order of $72,000,000. Optical services were set at $8,000,000 but are now $52,000,000.

Those who made such bad guesses probably will defend these staggering drags upon the British economy as being evidence of the very bad health of the nation. But here again examination of the facts shows both excessive use of the services and abuse of such things as eyeglasses, dental services, appliances, and drugs.

There will be those who will argue that this is only the result of the first impact of "pie in the sky," and that the ultimate costs will decline from an outrageous level to a merely exorbitant one. If we are concerned about our country's economic well-being—and I hope we are—then let us see whether there is a way in which individuals can prepay their medical costs and yet keep a close relationship between use and cost.

COSTS OF VOLUNTARY PLANS CAN BE CONTROLLED

The costs of prepaid medicine can be controlled in voluntary plans. The effect of use upon cost in our company with the long-time voluntary medical service plan has been made clear to the employees. Administrators of this plan have held several series of meetings with the participants who have been shown how use effects cost to them. Following each of these series of meetings there has been a decline in the visits to doctors, particularly in the number of visits for each illness. The result has been that contribution rates have been held in line or the increases minimized. Recently there has been a rate reduction. The employee has come to understand that he pays for what he gets.

Such results cannot be expected where the cost of mass medicine is to be provided by taxing everybody. Then there will be a scramble to get my share, and my share soon becomes everything I can think of to ask for. This bears the toney psychological label of the "instinct of self-preservation." Yet the simplest exposure to people in the mass and a nodding acquaintance with the field of temperament shows that we must expect this attitude of "after me you come first." Those of us who must turn out the world's goods and services, particularly for a price which someone else can afford to pay, are neither surprised nor appalled at this attitude. That is the way people behave here, elsewhere, now, in the past, and probably in the future.

In other mass benefits, we see this instinct at work. It seems to take the public about 2 years to know when to apply for benefits, another year to learn to abuse them, and up to 4 years more before the administrators forget the original objectives. With Government mass medicine, the misapplication of the benefits, the incompetence at the service level, the coddling of the hypochondriacs, the torturing of the statistics on use and costs, and the deterioration of medical standards would be an all-time high or low depending upon whether you were reviewing the failure quantitatively or qualitatively.

The spector of thousands of little men and women streaming over the country, making jobs out of compulsory medicine, making the costs exorbitant, making people's lives miserable with their rule books and myopic view of humanity is not very palatable to the citizen beyond the Potomac. Before we bring that upon ourselves, I hope we will expand the thousands of voluntary hospital and medical plans, tailor them to the needs of each individual group, keep the costs related to and controlled by use, and have the individuals budget and take care of their own hospital and medical needs, with the right to go in or stay out of the particular plan as they see fit and with the right to say who shall treat them.

CONCLUSION

In these remarks, I have tried to draw upon my personal knowledge in supporting what I believe is the wise position which has been taken by the membership of the Chamber of Commerce of the United States.

As for myself, this body which I inherited could stand improvement, but it is the one in which I must live, and as long as it is precious to me I want some control over who tries to keep it in repair.

Thank you, sir.

Senator MURRAY. You do not seem to have very much confidence in the general run of the American people, it seems to me, from your statement. You say here:

> With Government mass medicine, the misapplication of the benefits, the incompetence at the service level, the coddling of the hypochondriacs, the torturing of the statistics on use and costs, and the deterioration of medical standards would be an all-time high or low, depending upon whether you were reviewing the failure quantitatively or qualitatively.

It does seem to me that you do not seem to think very much of the competence of the American people. Of course, there are a lot of people who feel the same as you do about that. I read in the paper the other day about a convention held in New York by psychiatrists—that was some time ago—in which they went on to talk about the dangerous condition developing in the country, and indicated that in their judgment they thought the United States was filled with people that were largely affected by some psychoses, and one of them said that, in fact, the United States was rapidly becoming a grand transmogrified lunatic asylum.

Do you believe that it is that bad?

Mr. HORNBY. Well, I do not know who the psychiatrist was, but there are some rather humorous stories. I presume you heard of the fellow who went to a series of doctors and kept telling them as he went through the symptoms that, "These feathers are bothering me," attempting to brush some imaginary feathers off of him, and finally he went to a psychiatrist of this type, who went all through the man's symptoms and finally the psychiatrist asked the patient, "Well, what is your chief complaint?" He said, "Well, it is these feathers that are bothering me." The psychiatrist answered, "You get out of here; I don't want those feathers brushed off on me."

I think that is the kind of doctor who would draw that kind of conclusion.

This was an experiment. The insurance people were very apprehensive about it, when we had this last group, a group of about 300 employees. I insisted that they tell those employees what that plan did not cover.

When they responded with 35 or 40 percent the first time around and it took same weeks to get to 60 percent, the carrier was discouraged and said, "If we can just go in there and give them a sales talk"—and I said, "No; we won't give them a sales talk. We can afford to find out what the people will find out for themselves if we tell them the truth." I think 85 percent is a good indication that, if you give people the truth and let them make their own selection and suit it to their own needs and decide whether it does or does not fit their case, that they will behave rather intelligently.

Senator MURRAY. You refer constantly to mass medicine. What do you mean by mass medicine?

Mr. HORNBY. Well, I have tried to do something about these words. The word "health," as tied to medical care, has some connotations which it is not intended to have.

Medical care, as I have tried to point out here, does not bring about good health. Medical care, in the first place, is for the care of bad health. It is after you are sick, after your health has gone bad.

The things that bring good health I have tried to recite in here. So far as the word "mass medicine" is concerned, that is my effort to distinguish between medicine which we may select for ourselves on our own when we see fit, as against medicine which is going to be doled out to the masses.

Senator MURRAY. Medicine that is going to be doled out to the masses?

Mr. HORNBY. Right.

Senator MURRAY. You do not think this problem of cost of medical care is a serious problem at all?

Mr. HORNBY. Oh, sir, I do not believe that we would have installed these hospital and medical plans if we did not think the matter of costs of medical care—that is another subject, as I see it. Are we attempting to cure the matter of costs of medical care? Are we attempting to improve the health of the individual? Or are we attempting to force medicine upon him?

I say cost is a serious question. Otherwise, we would not have put these medical plans in.

Senator MURRAY. It is so serious that the Governor of your State has sought to remedy the situation down there by a program of medical care. Is not that true? That is Governor Warren of California.

Mr. HORNBY. Governor Warren is for Government medicine. At least, he has announced himself in that position. We do not happen to agree with him.

Senator MURRAY. He is the Governor of your State.

Mr. HORNBY. A good Governor.

Senator MURRAY. Apparently he has his ear to the ground and knows what the general sentiment of the people of California is with reference to this problem of medical care. Do you not think so?

Mr. HORNBY. I do not think so.

Senator MURRAY. You think he is incompetent, ignorant, or that he is influenced by some evil purpose in this matter; that he just simply wants to get out and do something that is injurious to the medical profession down there, or do you think he is sincere and honest about it?

Mr. HORNBY. Mr. Chairman, I happen to have been on a speaking tour in the East for my own corporation, and I spoke 23 times in 7 eastern cities, before representatives of over 350 financial houses, universities, insurance companies, and other institutions.

In discussing the political situation of California, which we must always discuss out our way, I have said that I think we have the best Governor that we have had for many years. I happen to know Earl Warren personally. As an individual, I think very well of him. He is a lawyer. I do not believe that Earl ever employed more than the staff of his own office.

I do not have a very high regard for our Governor's view as to how people react in the mass to this particular subject. That just happens to be a difference of opinion. I am sure he will not agree, and it will not bother him that I do not think well of his opinion on the subject, but it may bother me for some time to come.

Senator MURRAY. On all matters on which he thinks along the same line as you, you agree with him; and when he does not agree with you, you do not think he is competent; is that right?

Mr. HORNBY. Quite the contrary. I think a man should be entitled to an opinion based on what he knows about the subject and what his experience is in it.

Senator MURRAY. Thank you.

The next witness will be Katharine Lenroot and Dr. Leona Baumgartner.

STATEMENT OF KATHARINE F. LENROOT, CHIEF, CHILDREN'S BUREAU, SOCIAL SECURITY ADMINISTRATION, FEDERAL SECURITY AGENCY

Miss LENROOT. I am Katharine F. Lenroot, Chief of the Children's Bureau, Social Security Administration, Federal Security Agency. I have with me Dr. Leona Baumgartner, who has recently succeeded Dr. Martha Eliot as Associate Chief of the Children's Bureau. I would like to make a brief statement myself, and ask Dr. Baumgartner to speak more at length.

Senator MURRAY. You may proceed.

Miss LENROOT. I am appearing before you to testify in support of title VI, which is composed of part A, being Research in Child Life; part B, being Grants to States; and part C, Miscellaneous.

I refer to title VI of the National Health Insurance and Public Health Act. Since Martha Eliot, then Associate Chief of the Children's Bureau, testified before your committee on May 11 this year in favor of the National Child Research Act (S. 904) which is very similar to part A of title VI, I am going to discuss today only the maternal and child-health and crippled children's services provided for in part B.

While concerned primarily with children's programs, the Children's Bureau is interested in adequate provision for the health needs of all people. It is essential to the health and welfare of children that the general level of community health be high, and that family life be not weakened or disrupted by the avoidable death or illness of parents. To assure this end means that the supply of medical, dental, nursing, and other health personnel must be greatly increased, that hospital facilities be available, and that basic public health services be developed in every local community. Beyond this, ways must be found to eliminate financial barriers to good health care. Other persons from the Federal Security Agency have presented the needs in each of these areas. I want to speak directly to the special needs of children, recognizing that provision for these needs must be closely tied in with other aspects of health services.

The needs of children and their mothers must receive special consideration in any health program. Moreover, this most important group in our population, from the point of view both of the maximum results that can be achieved from health work and the future security and welfare of the Nation, should be given high priority as a matter of public policy. What we do for our children now will determine to a large extent the kind of citizens who will help guide the destinies of our Nation and of the world in years to come.

We in the Children's Bureau have had long experience in helping the States to develop maternal and child health and crippled children's programs. Ever since the Sheppard-Towner Act of 1921, we have worked with the States to achieve better health for our youngest citizens. We know that the services which can be provided under title VI are wanted by parents. We know that through the years mothers have asked for and received advice on how to care for themselves during pregnancy, and on how to feed the newborn baby, what can be done about Johnny's teeth and Mary's hearing. Every day we read in the newspapers of new scientific discoveries regarding how to prevent death and promote health in maternity and childhood. Only the other day the newspapers carried a story of new steps toward preventing that dread condition during pregnancy known as eclampsia, which has caused the death of many mothers. Dr. Baumgartner, who has come to the Children's Bureau to take Dr. Eliot's place as Associate Chief, will tell you more about the programs which have been developed in the States with the help of funds under the Social Security Act, and the kind of health and medical services they include.

There are a number of provisions in this title which seem to me particularly suited to the extension and improvement of services for children.

For example, title VI recognizes the great variation in what States can do for their children. Children are concentrated in low-income States and in rural areas. One-half of the children in the United States live in 32 States that get only one-third of the national income. The other half live in the other 16 States that have two-thirds of the national income. One-fourth of the children live on farms with only 12 percent of the national income. The proposal for variable matching puts more money into the low-income States and requires a smaller matching ratio from them. This is particularly realistic for children's services, and is accomplished by providing for allotment of States of the total amount available on the basis of the number of children in each State, the per capita income of the State and special factors relevant to the extent of the particular child-health problems or problems in the respective States.

There are two proposals in this title which are of particular importance in assuring a good quality of care. One is the recognition of the need for the development of State-wide programs for maternal and child-health services with a steady but gradual expansion. Emphasis is to be given at the beginning to areas of greater need. The rate of development is to depend upon the availability of personnel and facilities meeting standards established by the States for their programs.

A provision in this title which will make it possible for us to give much needed help in improving the quality of care to be provided in the programs is that not to exceed 10 percent of the amount appropriated may be used by the Federal Security Administrator for demonstrations, studies of the effectiveness of the administration and the provision of maternal and child health and crippled-children's services; to pay the expenses of personnel detailed at the request of the

State agencies; and for expenses of the Federal Security Agency in administration of these programs.

The amounts authorized for the first year—$25,000,000 for maternal and child-health services and $25,000,000 for crippled-children's services—are in line with what we know the States can use at this time. Year by year, the Federal Security Agency will bring back to the Congress a report of the progress which has been made and the need for funds in the succeeding year. Congress can then determine the amount to be appropriated for the purpose of further extension and improvement of these services for children.

In my opinion, we must move forward quickly to provide more adequately for the health of our children. Every day in the life of a child represents an opportunity to build strength or to weaken the possibilities for health in the future. An uncorrected handicap is costly to the child, his family, and the Nation, whether it be measured in financial terms or in terms of human suffering.

The people of our Nation will go to any lengths to save an individual child caught in a well, or suffering from leukemia, or in need of skin-grafting to prevent death from body burns. It is not so easy to be aroused to deal with problems that seem more impersonal. Somehow we have failed to harness sufficiently the love and concern of our people for children to organized effort to provide for all children the things that are essential to their health and development.

I ask you to bear these things in your minds and hearts as you give consideration to title VI of the pending bill.

I would like to add that in view of the urgent importance of going forward without delay in relation to the children of our country, if in giving consideration to this bill there appears to be problems of timing and the possibility of delay with reference to some aspects of the bill, I should like to ask the committee to consider whether it would not be possible to act now in relation to the needs of the mothers and children of our country.

Senator MURRAY. Thank you.

Of course, we are giving consideration to this. We have already had witnesses before us testifying on this same subject matter, and your statement this morning will be a very considerable contribution. We intend, just as rapidly as possible, to go over these different titles and get them reported out as quickly as we can.

Miss LENROOT. Thank you, Mr. Chairman.

Senator MURRAY. We will now hear from Dr. Baumgartner.

STATEMENT OF DR. LEONA BAUMGARTNER, ASSOCIATE CHIEF, CHILDREN'S BUREAU, SOCIAL SECURITY ADMINISTRATION, FEDERAL SECURITY AGENCY

Dr. BAUMGARTNER. I am Dr. Leona Baumgartner, Associate Chief of the Children's Bureau. I speak out of years of experience with the health problems of children in local communities. For the past 12 years I have administered the kind of maternal and child health and crippled children's services this title proposes, in New York City where, I remind you, children live not only in the crowded tenements of Manahttan but in the rural areas of Staten Island. Moreover, since 1923, I have worked intimately and professionally with these problems in western Kansas, in Montana, and in Connecticut, and I have studied them in Mexico and Europe. The two children in my own home have had poliomyelitis, and I know what it means to help handicapped children get on their feet again. For 12 years I worked each week in a children's hospital. I know the children who need these services and for whom this title was designed. I have, so to speak, been on the "receiving end" for quite a long time, and I know out of actual experience what these Federal grants mean in the way of better care for mothers and children in the local communities all over our country. I know, too, how enthusiastically parents and doctors support this type of program.

I have learned that better care does not come without careful organization in the community.

Let's start at the receiving end. Take first the problem of the prematurely born infant. Now nearly half of the babies who die before they are a month old die because they were born too soon or did not receive the kind of care they needed. Many of these deaths are preventable. Some progress can be made through actually reducing the number of babies born prematurely, because these babies have less chance of survival than their full-term brothers and sisters. So we know that some of our efforts must go toward preventing the premature birth of the infant.

Research studies in the past 15 years have shown that the number of infants prematurely born is reduced if mothers select and eat a really good diet during pregnancy. The amount of money the family has to spend on food, of course, influences what that family eats. But at every income level a better selection of food means better health for mothers and babies. Science has also demonstrated that good medical care during pregnancy can prevent premature birth. So maternal and child health agencies bring this information to mothers and help develop services for them in the local communities.

But despite all that is done and that can be done within the confines of our present knowledge, babies are still born prematurely. Many can, nevertheless, survive if they have the help they may need. Some need oxygen from a tank until they can breathe as full-term babies do. Some need frequent blood transfusions until their own blood supply is normal. Many must be fed by tube inserted through the nose until they can swallow normally. And, of course, most premature babies need incubators and special nursing care.

Obviously, such service is expensive—$15 to $20 a day in the critical period—and demands expertness of care. So it has been our experience that the average doctor and hospital welcome a premature center in the community. In New York City, for example, we began last November to transport in an ambulance babies from hospitals or homes unable to give all the specialized care that these babies needed if they were to survive. In the first 6 months, 40 hospitals out of the 106 in the city used the service, and 229 babies were transported to the special premature centers where good care was really available. Thirty-seven premature babies, born at home, were also brought to the centers. And every week, in fact almost every day, the local health department receives letters from grateful parents and physicians.

These services for premature infants are established in many parts of the country and the Children's Bureau is constantly urged by physicians, hospitals and citizens to help establish them in many other areas. In 1949, four States began new programs with the help of Federal funds; and others, including Florida, Montana, Ohio, Missouri, are making plans. Recently, successful centers for prematures have been set up in Maryland, Louisiana, Colorado, North Carolina, and West Virginia. Some of these are teaching nurses and doctors from other States how to give care according to the latest methods, and doing excellent research work, as well as caring for babies from their own and sometimes neighboring States.

Every premature baby who needs the special care a good center can provide should be able to get it, not just some. If he survives, he grows up to be the same kind of citizen as his full-term brother. Approximately 215,000 babies were born prematurely in 1947. Nearly 40,000 of them died. Expert care can save over a third of these, but this takes careful organization and development of services.

My second example illustrates the teamwork used in our crippled children's programs. Doctor, nurse, social worker, nutritionist, parent—each with a special skill must work together. The first difficulty one usually encounters is lack of money to pay for care, though shortages of doctors and hospital facilities and getting information to parents are also obstacles. Then, which child on the waiting list gets care first?

Medical urgency is a primary consideration. But sometimes other questions arise. Take the case of Jimmy, age 5, a bright child with cerebral palsy, who, doctors said, needed treatment, and got it under one of these programs. Jimmy's mother had five other young children, and she was expecting another baby. The other children had no time for Jimmy as they ran in and out of the little house. He was unhappy. He was unable to help himself; and his young mother, a well-meaning but distraught person, had much more than she could do. His father, a laborer, returned home late each day, too tired to bother with the kids. It was decided that both the boy and his mother needed help, and so Jimmy got the surgical and nursing care he needed at once. His operation was a success, and he got more than medical care. He learned to take care of himself, to put on his own clothes. This was a great help to his busy mother. He was taught to play with other children. He learned to enunciate words more clearly so he could be understood, to spell simple words. As he had a good intelligence and a happy disposition, the children learned to like him and to wait for him.

When Jimmy was ready to go home, plans were made to help him continue the progress which had been so well started. His mother was taught to let him do as much for himself as possible and how to serve his food in a way that it was easy for Jimmy to feed himself. It was amazing how grown up Jimmy felt when he could finally eat all by himself.

Before he started to kindergarten he was helped to understand that the children would stare at him until they got used to his uncontrollable and wandering movements. He learned slowly but surely how to do many more things for himself. And soon he was in first grade just as happy as any one of his classmates.

All this time Jimmy's young mother was helped with her family problems. As she found that Jimmy could look out for himself, she had more time for the rest of her family. She was even able to enjoy the new baby.

Jimmy is only one of more than 160,000 children in the United States with cerebral palsy. There are also approximately 500,000 children crippled by rheumatic fever and other heart conditions; some 500,000 who are orthopedically crippled; 4,000,000 are blind or have poor eyes; nearly a million are deaf or have poor hearing; 35,000 have diabetes; and 200,000 are suffering from epilepsy. These children and their parents have special problems and great numbers of them usually need help.

I have emphasized two examples of the way in which maternal and child health and crippled children's services have been developed in the past. There are many others. The Children's Bureau has appeared before you on numerous occasions and described the full scope of services given mothers and children in these programs. I know you are familiar with them, and I am sure that you will find evidence in every State of improved services for mothers and children under these programs. I know you are familiar with them and I am sure that you will find evidence in every State of improved services for mothers and children in the last 10 years. I want to emphasize that these are services which the doctors themselves support. It is they, as well as citizens, who ask for more and more help. The individual doctor working in his office and the individual parent very often cannot provide all that these children need. Herein lies part of the popularity of those services, that a health department or crippled children's agency pulls all the community's resources together and finds ways to fill gaps in service and real progress is made.

But can we be sure that these services pay? Is this an impractical dream of professional do-gooders? Does it produce results in terms of dollars and cents, of lives saved, of added reserves of man and woman power for the Nation? Do we have more adults who can care for themselves, and fewer community liabilities as a result? In spending money for the cheaper and sometimes less dramatic prevention of disease and disability, can we actually save money? Experience has proven that these programs do pay. Again let me take two examples—diphtheria, a dread disease at the turn of the century, was killing 40 persons out of every 100,000 of the population. Today there is only 1. This is the result of a preventive program of education and immunization of children.

The Hoover Commission in its report on the Federal Medical Services say that—

> Some 50,000 more persons would have died of this disease in 1947 if the 1900 mortality rates had prevailed. The 1947 cost to the Nation would thus have amounted to $30,000,000. The actual expense was $600,000.

This was taken from Federal Medical Services, prepared for the United States Commission on Organization of the Executive Branch of the Government by Committee on Federal Medical Services, January 1949, page 88.

Experts agree that the loss in infant lives due to diarrhea, or "summer complaint," decreased rapidly as doctors and nurses throughout the Nation educated the public to use clean milk and take better care of babies. In large cities, for example, physicians and nurses went through the slums, often climbing up one building, over the roof and down the next one, telling mothers in every flat how to boil milk, sterilize bottles and nipples, how to take care of the sick baby. Mothers learned how to prevent disease, and thousands of babies' lives were saved.

Thus, we in the Children's Bureau have learned that this kind of program pays dividends. Because we know there is still need for these services in many areas, we are glad to see that title VI of this bill provides for the first year $25,000,000, an increase of $14,000,000 over the present grants for maternal and child health; and $25,000,000 for crippled children's services, an increase of $16,500,000.

We know that three-fourths of our rural counties are still without regular maternity clinics, and many mothers living there go without the good maternity care which is the pride of American medicine. In 1946, there were still 177,690 mothers who did not have the services of a physician at the time of childbirth.

The American Academy of Pediatrics has just completed a Nationwide study of child health. This study by the doctors themselves concluded "that a child's chances for survival depend largely upon where he lives and the circumstances of his parents." Children in or near cities, they found, receive 50 percent more care than children who live in isolated areas. Rural children received less service of all kinds—hospital care, dental care, preventive service, including immunization. Does this lack of care help account for the fact that the infant death rate in some States is as high today as the national average was in 1921? Or that a baby's chance for survival is almost three times as good in one State as another?

The situation in the crippled children's programs has assumed the proportion of a national tragedy. In April 1948, the States reported more than 22,000 crippled children on waiting lists—children whose condition had been diagnosed by doctors as needing treatment but who were not getting it, primarily because of the lack of funds. By December 1948, the States reported that this number has increased to more than 30,000—an addition of 8,000 children in the intervening 9-month period.

The States indicate at least two major reasons why the waiting list is so large and why it is increasing at such an alarming rate. The first is that hospital costs—a major expense in the treatment of crippled children—have almost doubled. With funds limited as they are now by title V of the Social Security Act, fewer and fewer children can and will be cared for unless additional funds are secured. The Congress has recognized this by making a deficiency appropriation of $750,000 recently for the end of this fiscal year, but this money can't go very far.

The second reason for the increased number of children needing care at this time is the epidemic of poliomyelitis which reached its height over the country during the summer and fall of 1948. The National Foundation for Infantile Paralysis has spent $17,000,000 to provide care for many children during the acute stage of the disease, but it cannot provide treatment for residual paralysis and the long after-care needed to bring the child back to full recovery.

It is in the face of these needs brought to us day after day, gentlemen, that we support title VI of this bill, S. 1679. The States have indicated to us already the ways in which they could use additional funds and we know they will be wisely spent.

In closing, may I point out that I have limited my testimony to part B of title VI because we have already appeared in behalf of the research provision of the bill when it was heard separately as S. 904, the "National Child Research Act." It seems self-evident that past success has been achieved as a result of putting into practice what research discovers. Further advancement requires funds—first, for adding to our knowledge and, second, for putting into practice what we already know. This is why we support both parts A and B of title VI.

We urge its serious consideration as soon as possible.

Senator MURRAY. Thank you very much for your statement.

There is no doubt but what the members of this committee will recognize the importance of this program and are giving very earnest study to it, and we hope to be able to report something very shortly. Thank you.

Next is Mrs. Theodore Oxholm.

STATEMENT OF MARY H. OXHOLM, CHAIRMAN, SPOKESMEN FOR CHILDREN, INC., NEW YORK, N. Y.

Mrs. OXHOLM. I am Mary H. Oxholm, chairman of the board of directors of Spokesmen for Children, New York. This organization has a Nation-wide membership of individuals who have had wide experience in many fields of child health and welfare and who feel there is a need to appraise Federal legislation affecting children as it comes before Congress, to publicize it and to give what help they can in arriving at a decision on it. I thank you for this opportunity to appear before you.

For myself—I am not professionally engaged in child welfare work; I have three children; I have lived on a farm most of my life. I took an active part in developing rural health services which led to the establishment of a full-time local public health unit in Ulster County, N. Y., in 1947. It was one of the first six in the State. I mention it because local public health units seem to be one of the few points the two major bills have in common. I will come back to them later.

Thanks to the great strides made in medical research during the last 75 years, we find ourselves able to look on health as a natural right. A positive, affirmative concept of health is becoming a household topic, not alone in this country but throughout the world. It is epitomized in the definition of health drawn up by the World Health Organization, "Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity". The prospect of a healthy life is no longer a matter of chance. Two generations ago a woman had to bear 10 or 12 children in order to raise 4 or 5. Today she can decide how many she would like to have, have them, and be reasonably sure of raising them. Life expectancy has been increased to the point where a man can anticipate retirement and a life of ease instead of an early grave. Health has become a natural right. The great interest in the Blue Cross plan is another evidence of the people's desire for health. This awareness of its value, its availability and the monetary barrier that stands between abundant good health and the great majority of people has lead us to look for a way to surmount the barrier. It is from this new milestone in progress—this acceptance of health as a natural right—that we consider legislation providing health services. Whether they are to be provided for bill by bill or by the omnibus method, the basic principle of every man's right to health must prevail.

In studying these bills and their predecessors year after year, the philosophy and principles that motivate them take more definite form. With each new bill the choice becomes clearer, the intent more obvious.

We must choose between a continuation of the philosophy of the Elizabethan poor laws and health as a natural right—between sickness care that can only be obtained by the humiliating means of declaring oneself a pauper and a method whereby health services are made available to every citizen, not because he is rich or poor but because he is human.

There is danger of abuse either way, but to my way of thinking, the abuses inherent in withholding care when it is needed, in conveying to the State the right of disposal of any man's possessions, in basing the degree of care he shall receive on his economic status rather than his health need, are far greater than the possible abuses incurred in letting each man decide for himself how much of his own burden he can carry. The Hill bill goes so for as to provide that wherever possible the Government shall not only be reimbursed by the recipient of charity but that his estate shall be assessed after his death to the limit it can pay the State. I had to read that bill twice and then look at the title page to believe it had actually been introduced in our Senate.

What of the other principle? Are we witnessing the return of the true meaning of charity in our efforts to make health the right of every man? Certainly each man should bear as great responsibility as his shoulders can carry, but also the small percentage who cannot must be able to avail themselves of their natural rights without humiliation and indignity. Is a Government employee still to decide what a free man can afford or how he is to spend the little he has? Should a man's ability to make his own decisions be based on the extent of his worldly possessions? Let us go a step further: Is the degree of care a sick person receives to be decided by its cost? Does the life involved justify the expense? If a man's wife is ill, who is to decide the value of her life—the husband who loves her, whose homemaker she is, whose children she has borne and raised—or a Government administrator? There are two points of view about this question. If it were your wife, you know whom you would want to make the decision. We are one kind of people—Americans. We want one kind of care, good, good enough for your wife, good enough for my husband. In writing legislation for our future health, let us adhere to this principle.

When I contemplate the future of this country, I think of it in terms of what it will be for my children, my grandchildren, my great grandchildren. I imagine you men feel that way about it too, about your children. And I know that I don't want my descendants ever to be subjected to a means test. No. Not one of them. Never!

When they look back 50 or 75 years to this present time, will they hail us as the generation that cast aside the shackles of a means test, the generation that recognized health as a natural right and in its wisdom found a way to make health services a common right, a common, and let me say, constitutional right? Or will they say we botched it? That we put private interest above the good of the Nation? That we hadn't the courage to stand fast on principle and the wisdom to interpret it in a way that made it a new bulwark of democracy?

I have wished for a long time that you Senators and Congressmen would take this problem directly to the people. We need to have the issue simply and clearly presented to us. We are confused by a morass of shibboleths and misstatements in the press, on the radio, in passionate, partisan debate, and in educational material. I, for one, believe you would get a response that would help you reach a decision that was clearly the will of the people. Whatever legislation is enacted will affect each one of us personally and directly; it will be tantamount to another amendment to the Bill of Rights. We need to know the principles involved, the choices that must be made, the future that is being planned for our children.

In reviewing these bills year after year, one is aware of continuous progress and development of plan and a reflection of the gradual evolution of public opinion. It raises the question of whether the enactment of any bill providing sickness care at this time might not be premature. Only 2 weeks ago the American Medical Association made a new move in the direction of prepaid health insurance. And a month ago an excellent report by Dr. Hugh Leavell of Harvard Medical School, on the operation of the British health plan appeared in the Journal of the American Public Health Association which should be of real value in helping us to write the kind of legislation we want.

If you do not have a copy of that I will leave one for you.

Senator MURRAY. You may do that.

(The document referred to will be found in the files of the committee.)

Mrs. OXHOLM. Is there not a need for further research into this whole health problem before it is dealt with by law? Should a survey of the unmet needs in our present services be made, so we will know the extent to which aid is needed? Should we ascertain just what a full-time local public health unit contributes to the health of its community and what needs it does not meet? Is there a political subdivision anywhere in the United States where the residents are 100 percent covered by health insurance of some kind? If not, would it be fearful to establish a demonstration area and test the system? How effective is health education? Do we know what motivates people to seek better health? Is it wise to create legislation to pay for professional education in one field? Think of the precedent it would set.

One wonders, too, if these bills are in some measure written for political expediency and designed to appease certain pressures—an aroma of medicine, perhaps, the voice of monopoly, or the faint echo of campaign promises, a desire to meet the surging demand of the people for a better way of life.

It occurred to me as I read these bills that the word discrimination has been bandied about a great deal. Provisions are made in both the Taft and Murray bills for special services to children. And that is good. But why children only? What about grandma or grandpa—or Aunt Lizzie? What affects more adversely the health of children than to have their parents burdened, often for years, with the sole responsibility of caring for an ailing older dependent? Regardless of how unselfish or loving the care provided grandpa or Aunt Lizzie is, it is too often the children who pay for this care. And equally important: What about the health of you men? And us women? The people have indicated that they want good health for all and I doubt if they will be satisfied with a bill that provides anything less.

Perhaps it will develop that the way to handle this question of health services will be piece by piece, or bill by bill. Should that be the case, it might be in order to pass a bill promoting full-time local public-health units first. Or make it a companion bill to one for school health services. It has the advantage of being endorsed by both Senator Murray and Senator Taft, the American Medical Association, and the administration. What a bill! It is the foundation of positive, constructive health services. Without it, provision for school health services would be a waste of time and money, because a school health examination often requires follow-up work and without a local public-health unit there would not be adequate personnel for that work. In Ulster County the demand for a local public-health unit grew out of the work done by our rural public health nurses. Those nurses brought health services and health education right to the door of every farm-house and right into the life of every farmer, and every villager, and in 7 years' time nothing would do but Ulster County must have its own health department. We have learned to think of health as a desirable state of being, not just freedom from disease, and we are proud of having our own health department.

Even with local health units there still remains the problem of how to meet the cost of individual health services and sickness care. When a bill providing for them finally becomes law, let it establish the right to health for all time to come and leave the means test with the Elizabethans, where it belongs.

Senator MURRAY. Thank you very much for your very splendid statement.

The next witness will be Dr. Joseph S. Wall.

STATEMENT OF JOSEPH S. WALL, M. D., CHAIRMAN, COMMITTEE ON LEGISLATION, AMERICAN ACADEMY OF PEDIATRICS

Dr. WALL. My name is Dr. Joseph S. Wall, and I would like to say that this statement is on behalf of the American Academy of Pediatrics.

The American Academy of Pediatrics, which I have the honor to represent as chairman of its committee on legislation, by action of its executive board on April 16, 1949, disapproved the passage of S. 5 and bills of similar purpose, such as S. 1679, now under your consideration.

Regarding S. 1679, the National Health Insurance and Public Health Act, we have never before studied a bill presented to the Congress the preamble of which has contained so many misstatements, inaccuracies, and observations at variance with the truth, evidently for purposes of propaganda, as are contained in section 2 under the caption "Declaration of Purpose."

Seven conditions are named in section 2, a few of which must be admitted to exist, based largely upon geographic and economic situations, which the bill attributes solely to one factor, namely, "our archaic system of paying for medical care."

For purposes of clarity, let us for the moment rearrange but not change the phraseology of the paragraph in section 2 beginning on line 7, page 5, and ending on line 2 on page 6, to wit:

> The following conditions [numbering seven] have resulted from our archaic system of paying for medical care based on public and private charity for the poor, on unpredictable and often unbearable costs to the otherwise self-supporting and on disproportionate charges for the well-to-do.

Who but the adherents of socialized medicine and those who see in the bill free medical care—but will not receive it—can charge as archaic a system of paying for medical care which is and always will be a basic economic law for the purchase of personal services in accordance with the principle that the laborer is worthy of his hire? Surely, the vocal labor leaders propagandizing this measure would be the last to deny this principle as it applies to the workers they represent.

Webster defines the adjective "archaic" as "pertaining to an ancient time, custom, or relic."

Those who designate the present system of paying for medical care as archaic, although a better definition would be time-honored, might have perused Webster a bit further and found adjoining the definition of archaic another word arising from the same stem, which many of these propagandists, from their vociferous utterings, would like to apply to physicians distributing medical care. The word is "archaeopteryx," defined by Webster as a "fossil bird of the Jurassic age, having teeth, vertebrae in its tail, and claws on its wings, being a link betwen birds and reptiles." Is it possible that our patients, many of whom have been our loyal adherents through the years, would regard us as a flock of vampires or the vicious hybrids known as archeaopteryx? If so, why do they still employ us, usually with grateful appreciation for medical services rendered? Archaic had better be eliminated from section 2.

Senator MURRAY. You do not approve the word "archaic"?

Dr. WALL. Hardly, sir.

Senator MURRAY. I noticed an article in the paper yesterday referring to the system of collecting for medical care as being somewhat in the nature of an archaic system, because they are criticizing it and they claim they are being compelled to greatly expand the services of collecting income taxes, and the doctors are all insisting on cash payments so that it is very difficult for the income-tax people to keep a line on how much they take in.

Dr. WALL. I think in certain crowded cosmopolitan areas it might take place. I do not think it does in the city of Washington.

Let us for a moment examine the seven "conditions" ascribed to the so-called archaic system of paying for medical care.

Condition 1, section 2, page 6, line 3: "The inability of the vast majority of our people to meet the shattering cost of serious or chronic illnesses." This statement is entirely out of keeping with the truth. The majority of our people have been able to meet the costs of illness, however shattering, or have had medical services provided for them under the so-called archaic system.

Senator MURRAY. We had some testimony the other day to the effect that 65 percent of New York's relief load consists of families which were self-supporting ordinarily but as a result of costs of medical care they became victims of this situation. Do you recognize that?

Dr. WALL. I recognize that the costs, Senator, have often been shattering, but they have ben met in the past; and if the families were unable to pay, they have received service anyway.

Personally, I know of the shattering costs of medical care, because 2 years ago my costs for hospitalization and care amounted to between four and five thousand dollars, so I speak from personal experience, too.

Senator MURRAY. Of course, any family who finds itself in such a situation where they cannot afford to pay for medical care finds that the condition is very shattering to their lives.

Dr. WALL. No doubt.

Senator MURRAY. And it seems to me that the average person in that situation does not get the proper kind of medical care, even though, as you say, they may get some care; but they do not get the best medical care. Do you think so?

Dr. WALL. I doubt, though, Senator, if that applies to the vast majority of our people. That is the wording of the section.

Senator MURRAY. I think that the vast majority of our people are bothered with this problem of medical care, because I know in my State of Montana I go around the State and people have talked to me about it, and they tell me of their experiences. I think the same situation is found in all parts of the country, that the problem of the costs of modern medical care constitutes a very severe ordeal for them.

Dr. WALL. I will admit, most assuredly, the costs of medical care—I mean hospitalization, nursing, drugs, and all the rest—are inordinately high at the present time.

Senator MURRAY. Very high.

Dr. WALL. Very high at the present time, no question about it.

Senator MURRAY. Some people who can afford it are willing to pay for it. For instance, it is not an unusual thing for a person to have to pay $2,500 for a single operation; is not that true?

Dr. WALL. That is true.

Senator MURRAY. What ordinary person can pay such a fee as that?

Dr. WALL. I do not believe, Senator, the ordinary person would be asked to pay that fee.

Senator MURRAY. Is not there something wrong about a system that permits them to charge a fee of that kind to one person and a different kind of fee to another person, and so on? A doctor sometimes assumes, because a man is apparently dressed well and is getting along all right, that he can afford to pay a big fee. He is charged a big fee, and the average man does not want to say that he is a pauper and he goes ahead and pays the fee, but it is a very severe load on him.

It does seem to me that there should be some way of spreading that cost so as to not make it fall so heavily upon the individual who happens to be unfortunate enough to have a serious illness in his family.

Dr. WALL. I believe there is a way of spreading it, and that is by enlistment in the various organizations of Blue Cross and other hospitalization plans, which insure against those inordinate costs.

The wealthy man can go in as well as anyone else. May I continue?

Senator MURRAY. Yes.

Dr. Wall. Sampling of our population by well-conducted polls has shown decidedly that the majority of our people do not wish a change in the present method of payment for medical care, nor can it be denied that the present and time-tested system of paying for medical care has failed to contribute its share "of our Nation's strength, productivity, and wealth," to quote from the second paragraph of section 2.

Condition 2: "The inability of most of our people to benefit from modern preventive medicine." This statement is an absolute falsification of fact, of which I may speak with the authority of a pediatrician in practice among children for over twoscore years. As the twig is bent, so the tree will grow. Pediatricians are those who control the growing human plants, who form a special group of physicians devoting two-thirds to three-quarters of their time to preventive medicine and who, with the aid of the general practitioners embracing their methods, contribute most largely to the practice of preventive medicine. So that, in my opinion, preventive medicine is practiced and is embraced by those who would embrace it.

The increase of over a score of years of the span of life has been due largely to preventive medicine as applied to infants, children, and adolescents, so that it may no longer be said "that the good die young," for good preventive medical care has enormously reduced the morbidity and mortality among the young in all categories save one, injuries and deaths from accidents, these resulting from the tensions and perils of the machine age and not from any lack of preventive medicine.

Condition 3: "A critical shortage of physicians, dentists, hospital administrators, dental hygienists, nurses, sanitary engineers, and other health personnel." This is admittedly true in part, but will the institution of compulsory health insurance increase or decrease the attraction of medicine and allied professions as careers for prospective students? The obvious answer is that it will decrease, and act as a deterrent to the enlistment of physicians in the profession of medicine.

Condition 5: "Wholly inadequate provision for the health needs of our farm families and agricultural workers." These groups through the acquisition of good roads and modern transportation are within a few hours' reach of facilities for the most modern medical and surgical treatment, as well as sharing in the benefits of nearby facilities now being extended to rural areas through the Hill-Burton Act and other legislative acts of the Congress.

The same statement applies to condition 7, relating to maldistribution of both personnel and facilities. One might justly criticize the wording of this condition which contains the phrase "other (areas) which suffer an almost total lack of 'decent medical care'." If not decent, these areas must have only indecent medical care—the bill might have been drawn with more attention to the choice of truly descriptive adjectives.

Also, in condition 7, occurs the paragraph:

> Because prolonged failure effectively to relieve these shortages and to correct this maldistribution will result, inevitably, in the further extension of medical care directly by Government agencies.

Is this a threat or a delusion? The same question may be pertinent to the next paragraph threatening a—

> system of state medicine, paid for from tax funds and rendered by regimented doctors.

Is this a post hoc propter hoc and may we ask in the words of Lo, the poor Indian (who has never received "decent" medical care under the auspices of governmental medicine), "How! How is it going to work out that way?"

You have a number of Indians, Senator, in your country out there.

Senator MURRAY. And they are in pretty bad shape, too, from the standpoint of medical care.

Dr. WALL. That is right. We would like to rearrange but not change the wording of section 2 (G), in the interest of clarity, line 23, page 8, to line 2, page 9, to wit:

> By establishing a system of prepaid personal health insurance on the principle of social insurance, to provide a sound economic foundation for our free system of medicine, and to correct the maldistribution of health personnel and facilities.

The bill thus obligates the measure in establishing a free system of medicine, but in the next breath on the opposite page, section 3, page 9, line 3, retracts the promised bait of a free system of medicine by a diametrically opposite promulgation actually providing for the degrading, obnoxious, horrid (sic) "means test," as follows:

> In establishing a system of national health insurance, it is the policy of this act that those persons and their dependents who are insured under the provisions of the act shall pay for its benefits in proportion to their incomes, and shall, therefore, receive its benefits as a right and not as charity.

A "means test," the universal economic law under which we all live, pay our income taxes, purchase our food, clothing, and shelter, rears its ominous head again on page 74, line 3, section 422 (b), to quote:

> If regular payments from its members are required for purposes of financing the cost of providing the medical care and the maintenance and operation of the cooperative (farmers' experimental health cooperatives) and are graduated in relation to income or income groups.

But in title VI, in which we as pediatricians are especially interested, relating to maternal and child care, appears the prohibition in regard to acceptance of a State plan, page 96, lines 13, 14, and 15, that such plan shall (6)—

> provide that determinations as to the children to be furnished services under the plan shall be made without regard to economic status.

That is the only phrase in title VI to which we take exception.

The American Academy of Pediatrics has repeatedly protested against this principle of free treatment for all individuals by the Federal and State governments, in the following language:

The American Academy of Pediatrics, regarding the provisions for maternal and child welfare (referring to the National Health Act of 1939, S. 5, S. 1679, and similar bills of the 81st Cong.) favors the use of public funds to provide such services to those groups of the population unable to pay for medical services, to the end that the standards of medical care may be maintained at a high level among such groups.

The Academy of Pediatrics does not favor the use of Federal funds for those able to provide good medical care from their own resources.

The American Academy of Pediatrics again opposes the passage of legislation which violates the principles set forth above and registers its protest against the adoption by the Congress of S. 1679 as at present written.

In conclusion, let me again revert to section 3, page 9, lines 4 to 8, to wit:

> Those persons and their dependents who are insured under the provisions of the Act shall pay for its benefits in proportion to their incomes, and shall, therefore, receive its benefits as a right and not as charity.

The insinuations and aspersions implied in this paragraph and cast upon charity associated with the bestowal of medical care by physicians, we resent in no uncertain terms. Since when has charity been condemned and decried as an attribute of humanity?

From the time of scriptural writings charity has ever been looked upon as one of the humanities worthy of praise and not of censure. Indeed, Holy Writ tells us in I Corinthians that—

> Charity suffereth long and is kind; charity envieth not; charity vaunteth not itself, is not puffed up, rejoiceth not in iniquity, but rejoiceth in the truth; and now abideth faith, hope, charity, these three; but the greatest of these is charity.

A recent report (Medical Economics, March 1949, p. 73), based on the Sixth Medical Economics Survey, of the time given to charity by physicians states that—

> Six hours a week were donated to charity patients by the average independent physician in 1947. (This was equal to about 10 percent of the practitioner's total working hours.)
>
> Among all independent physicians in 1947 the total donation exceeded 36,000,000 charity-hours.
>
> The dollar value of those donated hours was more than $135,000,000.
>
> Eighty-eight percent of all independent physicians attend charity patients to some extent.

Can any member of any profession in this audience within the reach of our voice challenge this record, or even match or exceed this tithe of service to humanity which is rendered by physicians?

In conclusion, Senator, it was brought to my attention—and Miss Lenroot confirmed that request this morning—that perhaps, were this bill not to be passed in toto, certain sections might be taken up separately. The Academy of Pediatrics favors practically all titles up to and including title VI.

In regard to the education of health personnel, the academy is on record as favoring aid to the medical schools if and when such aid cannot be obtained from private sources.

Also in regard to hospital construction, in regard to the public-health units, and particularly in regard to section VI, Research and Child Life, which Miss Lenroot has discussed, we have already testified on behalf of the academy in regard to S. 905. In that regard we are opposed to the whole bill as it is presently written.

Senator MURRAY. We have had no help from the American Medical Association in trying to formulate this legislation.

Dr. WALL. I am sorry.

Senator MURRAY. If we had known of your expertness in this field, we might have employed you and asked you to sit in and help us to prepare the proper phraseology.

Dr. WALL. Such as "archaic"?

Senator MURRAY. Yes. My understanding is, you are utterly opposed to archaic, and you are very favorable toward charity.

Dr. WALL. Yes, sir.

Senator MURRAY. Thank you.

Dr. WALL. Thank you, Senator.

Senator MURRAY. The next witness will be Mrs. Jack B. Fahy. Good morning, Mrs. Fahy.

STATEMENT OF MRS. JACK B. FAHY, EXECUTIVE DIRECTOR, AMERICAN PARENTS COMMITTEE

Mrs. FAHY. My name is Kathleen Fahy. I am testifying today as executive director of the American Parents Committee, a group of mothers and fathers who are interested in the well-being of all children.

I would like to file my statement for the record.

Senator MURRAY. You may do so.

(The prepared statement submitted by Mrs. Fahy is as follows:)

STATEMENT OF MRS. JACK B. FAHY, EXECUTIVE DIRECTOR, AMERICAN PARENTS COMMITTEE

My name is Kathleen Fahy. I am testifying today as executive director of the American Parents Committee, a group of mothers and fathers who are interested in the well-being of all children. George J. Hecht, publisher of Parents' magazine, a magazine which reaches more than 1,000,000 families, is chairman of the American Parents Committee. It vice chairmen are Dr. Henry Noble MacCracken, president emeritus of Vassar College; Mrs. Dorothy Canfield Fisher, novelist and educational authority; Walt Disney, motion-picture producer; and Robert L. Johnson, president, Temple University, and chairman of the Citizens Committee Supporting the Hoover Commission.

The American Parents Committee is supporting the provisions of title VI of S. 1679. We heartily endorse part A, which would provide research in child development. We would like to call attention to S. 904, introduced by Senator Douglas in behalf of himself and Senators James E. Murray, Elbert D. Thomas, Hubert Humphrey, Estes Kefauver, Claude Pepper, Margaret Chase Smith, George D. Aiken, and Charles W. Tobey. Hearings were held on this bill, which is similar to part A, in May; and we urge early action by this committee.

Today our testimony is confined to part B of title VI, which would increase Federal grants to the States for maternal, child-health, and crippled-children care. The committee supports these provisions because it believes that every child born in the United States should be given, by every possible means, the birthright of growing up healthy and strong. Every child who must sit on the sidelines watching the healthy children enjoying life testifies to our failure, to our criminal negligence of that child as a human being, as a future citizen.

When one thinks of children, one automatically pictures a healthy, red-cheeked, mischievous child. Unhappily that picture is not true to life. Children have more illness than any other age group except for the sicknesses of old age. You know the nagging pain of teeth cavities—the average child has six teeth already decaying when he enters school. There are 1,000,000 children in the United States today who have trouble hearing—a shout, "Come out and play," goes unheard by them. Four million more children are having trouble seeing—they are the ones who are never chosen for any team because they always miss the ball. Nine hundred thousand more are handicapped by tuberculosis, epilepsy, diabetes, and orthopedic defects.

Some of the diseases which strike children are not just cripplers. They are killers. Despite the new modern cures, pneumonia, enteritis, diarrhea, rheumatic fever, and heart disease are still major causes of death among children. In just one age group, the infants under 1 year, there were almost twice as many fatalities from illness from Pearl Harbor to VJ-day as there were Americans killed in action. The death rolls of our armed forces fill us with horror, but the obituaries of children in our newspapers go unnoticed except by their families.

This large toll of illness and death among the Nation's children need not be. Death and handicaps from disease can be prevented or lessened by proper care. Take the example of the benefits from prenatal care. Alabama found that the mortality rate of Negro mothers who received prenatal care was 60 percent lower than those who had none. The babies of those mothers with care had a 51 percent better chance to live through their first month. Connecticut and Minnesota have been able to cut their maternal mortality rates down to 9 deaths for every 10,000 live births, proving that the high rates of other States, 30 or 31 per 10,000, are unnecessary.

But how many children and their mothers receive proper care? The large number of children who are not enjoying full health would answer that question, "Only a few of us." The statistics of the care afforded mothers and children in the last year supports their answer.

Only 25 States have rheumatic-fever programs. They care for only 6,000 children. What happens to the 494,000 other children with rheumatic fever who have the misfortune to live in other States?

Only 12 States have cerebral-palsy programs. Yet, the 100,000 to 160,000 children suffering from this affliction are spread throughout the United States.

Only nine States have impaired-hearing programs. Yet, as I have pointed out before, there are 1,000,000 children in the United States handicapped by hearing defects.

In many States, crippled-children clinics are held only once or twice a year. Many States have had to limit service to emergency cases. In December 1948, more than 30,000 crippled children were waiting for treatment in 31 States. The other 17 States keep no list of waiting children. How many more crippled children are there in every State who are hidden away at home without ever knowing of the care that might help them?

In 1948, there was no available public-health agency to serve 13,000,000 children in the United States. Only a few more than half of our counties had full-time health agencies. In the rural areas, three out of five counties have no regular maternity clinics.

These are all figures. But these figures mean children who are suffering needlessly. They mean the 9-year-old boy in Oklahoma whose mother writes: "He has never talked. He can hear and knows almost everything you say to him, and every morning he begs to go to school when he sees his neighbors' children going. I 'taken' him to Wichita, and they said they could 'learn' him to talk and would take him in as soon as they had an opening. But that's been a year ago last December 12, and George is getting so old."

They mean the little 9-year-old boy in Arkansas who had six of his front teeth knocked out last year at school. The school nurse said, "They really need to be fixed now, for his mouth is drawing where his teeth are out."

Why are we doing so little to help these children grow strong and sturdy, able to run around and play with the other children? The answer to that question is lack of money, an answer which seems embarrassingly paltry when given to these sick children needing care.

The parents of these children don't have the money to take care of them. One-sixth of all the families in the United States support more than one-half of all the children, and 62 percent of them had annual incomes of less than $3,000 a year in 1946! Almost half of all city children that year belonged to families with incomes below $2,750. Twenty-five percent of all the children in the United States live on farms, but the farm families earn only 12 percent of the national income. How can these families carry the extra and expensive burden of care for sick or crippled children?

The average cost today for a day's hospitalization is $10. Children with harelip or club feet are treated in the hospital for 10 days to 2 weeks. With osteomyelitis or rheumatic fever, children are often in the hospital for 6 months or longer. What family budget can stand a hospital bill like that?

As one mother in Baltimore, Md., said succinctly, "I have a 7-year-old cerebral-palsy son. He does not walk or talk. It would cost $3,000 to send my son to school a year. My husband's salary is $3,000 a year."

Or another mother in Illinois: .'This child wasn't doing as normal children should, so they began to take him to all the crippled children's clinics. They have called his case mental asphasia (clot on brain). Now, we have to develop the other part of the brain that is never used only in cases like this, and it has to have special training. This school costs $5 per hour for lessons. Then, they take him on Mondays to a class of similar methods that the State pays for. Then, it's just the expense of travel and someone to work in the father's place. So, all in all, it takes $70 per month for this child's eight lessons. He is learning so fast; is a brilliant child. If they could possibly keep these lessons up, he would not be too inferior to children of his age when he is ready to go to school."

The States don't have the money to take care of all these children who need help either. Nor is the burden evenly shared by the States. Thirty-two States which together receive only one-third of the national income have one-half of the children in the United States as their responsibility. The Southeast, which has 57 children for every 100 adults, has a per capita income of only $883. In that area, Florida for example, has 2,000 crippled children needing care, but the

State can only afford to use 175 of 350 beds available for crippled children in the hospitals and convalescent homes. The far West on the other hand, with only 32 children per 100 adults, has a per capita income of $1,559. Studies have found children in one State receiving three times as much private or public health care as they get in another State.

The grants, administered by the Children's Bureau, which would help out the States under title VI, part B, are not a new, revolutionary step. For the past 12 years, the Children's Bureau has been helping the States with grants for their maternal, child-health, and crippled-children programs. At present the Bureau is giving the States a total of $18,500,000, a pittance in comparison with the needs of the 46,000,000 children in the United States.

These limited grants have been put to good use. One of the most urgent needs of maternal, child-health, and crippled-children services is the need for trained personnel. About $1,500,000 of Federal funds was spent for training last year, half assisting individual students and half developing graduate courses at various universities. For example, courses in premature infant care—one that is badly needed, for 46 out of every 100 babies who died in their first month during 1947 died because they were born prematurely—were started at the University of Colorado and Louisiana State University through help from the Children's Bureau. Courses training nurses in advanced pediatrics and maternity nursing were supported by Federal grants at Wayne, Indiana, Boston, Columbia, Cincinnati, and Vanderbilt Universities.

Several States have set up projects with the help of these grants. During the past year, a program in Alabama cared for Negro mothers. One in Florida provided care in an area where there are many migrant farm laborers. A project in South Carolina served expectant mothers with tuberculosis. Five States gave complete medical and hospital care for a limited number of premature infants. A special project was developed in Massachusetts caring for the preschool children of war veterans attending Harvard University in an effort to provide data on the cost of providing all medical services for this age group. A project was set up to give complete pediatric care for children in one small area in Washington, D. C. Three States set up projects providing complete dental care to children in a limited area.

Looking at the child-health picture of the United States as a whole, these projects are just scattered pinpoints on a large map. How much more the States could do with the grants suggested under title VI, part B. They could start on the large job of reaching every county, no matter how rural, with maternal and child-care services. They could expand their crippled-children programs so that a handicapped child could get help, not matter what State he was growing up in. They could set up dental clinics so that the new development of painting children's teeth with fluorides to reduce decay would reach all children, enabling more to grow to adulthood with a full set of teeth.

The universities would have the opportunity to offer more advanced training instead of just the basic courses which leave a nurse or general practitioner almost helpless when faced with a 7-year-old who cannot walk or talk. The Children's Bureau is working now on a national plan for developing training centers jointly with State health departments and universities to train workers to deal with such conditions as cerebral palsy, rheumatic fever, cleft palate. With the funds available under title VI, part B, this plan, and all the States' plans, could be put into effect.

The American Parents Committee is supporting title VI, part B, but there is one question our committee would like to raise. Part B does not insure that the children of migrant families, those children who belong more to the United States as a whole than to any one State, will receive any health care. These children, numbering more than 1,000,000, because of their inadequate diets, substandard living conditions, and transitory life, are in great need of health care. The United States Public Health Service has found through surveys that migrant families suffer from disabling illnesses at a far higher rate than the rest of the population. Out of 83 children of migrant families studied by the Children's Bureau in Hidalgo County, Tex., only three were found not to be in need of some kind of medical or dental care. Two-fifths of the children, for example, had positive reactions to tuberculin tests. Almost one-quarter were suffering from malnutrition. Nearly one-sixth of the children had rickets. Only 5 out of the 58 women who had delivered babies in the previous year had any kind of prenatal care.

In the 1947 annual report of the Commissioners of Social Security, Mr. Altmeyer recommended that in developing State-wide programs of maternal, child-health, and crippled-children care, such services should be provided without discrimination as to residence as well as to race, creed, color, or national origin. But in title VI, part B, no such provision to prevent exclusion of migrant children is included. While we realize that even under this bill the State programs will be limited, we believe that where services assisted by Federal funds are available these children of the families who make possible the fresh fruits and vegetables on our grocery stands, should not be turned away simply because they have not lived in the State long enough.

With that suggestion only, the American Parents Committee is supporting provisions of title VI, part B because upon the health of the Nation's children depends the Nation, because so many sick or crippled children are asking for help, because that help cannot be provided without some assistance from the Federal Government. Passage of these provisions would be a step, if a small one, in giving the children who would otherwise be handicapped by disease or accident a chance to be like other children.

Mrs. Fahy. I would like to emphasize one point that has not been brought out by other witnesses. First, I should say we are interested in S. 904, part A, title VI.

The American Parents Committee is supporting title VI, part B, but there is one question our committee would like to raise. Part B does not insure that the children of migrant families, those children who belong more to the United States as a whole than to any one State, will receive any health care. These children, numbering more than 1,000,000, because of their inadequate diets, substandard living conditions and transitory life, are in great need of health care. The United States Public Health Service has found through surveys that migrant families suffer from disabling illnesses at a far higher rate than the rest of the population. Out of 83 children of migrant families studied by the Children's Bureau in Hidalgo County, Tex., only three were found not to be in need of some kind of medical or dental care. Two-fifths of the children, for example, had positive reactions to tuberculin tests. Almost one-quarter were suffering from malnutrition. Nearly one-sixth of the children had rickets. Only 5 out of the 58 women who had delivered babies in the previous year had any kind of prenatal care.

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There seems to be a trend now in this Congress to watch the dollars, but I think in title VI you are not dealing with dollars alone, you are dealing with children and children cannot be counted up in an amount of money and cannot be economized if this country is to be a strong nation.

We hope that title VI can be lifted out of the bill and acted upon.

Senator Murray. Thank you very much, Mrs. Fahy.

This concludes the hearing for today.

We will meet at 10 o'clock tomorrow morning.

(Whereupon, at 12:10 p. m., an adjournment was taken until 10 a. m., Tuesday, June 28, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

TUESDAY, JUNE 28, 1949

United States Senate,
Subcommittee on Health of the
Committee on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senator Murray.

Senator **Murray**. The hearing will come to order, please.

Mr. Ray D. Murphy, vice president and actuary, Equitable Life Assurance Society of the United States, speaking on behalf of the Life Insurance Association of America and the American Life Convention, will be the first witness this morning.

STATEMENT OF RAY D. MURPHY, VICE PRESIDENT AND ACTUARY OF THE EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES, ON BEHALF OF LIFE INSURANCE ASSOCIATION OF AMERICA AND AMERICAN LIFE CONVENTION

Mr. **Murphy**. I will read my prepared statement, if I may.

Senator **Murray**. Very well, you may. How long will it take?

Mr. **Murphy**. It will take just about half an hour, I estimate.

Senator **Murray**. I was going to suggest that if you wish you may summarize parts of it, in order to speed up the hearing and save time.

Mr. **Murphy**. I think we have so condensed our presentation already that if I tried to summarize it, it would take me fully as long as to simply read it.

Senator **Murray**. All right, follow your own idea as to how to present your statement. I do not want to tell you how to do it, or to rush you. It was simply a suggestion.

Mr. **Murphy**. Yes.

Mr. Chairman and members of the committee:

This statement has reference to title VII of S. 1679. It is respectfully submitted on behalf of the American Life Convention and the Life Insurance Association of America, jointly representing life insurance companies which underwrite over 95 percent of the life insurance in force in United States companies.

The intimate relationship of the life insurance business to health and longevity is too obvious to need elaboration. As a matter of fundamental principle, the life insurance companies are vitally interested in improving the distribution of hospital and medical care and in further advancing the general health level of the American people.

By the same token, they are naturally concerned with any proposal which, in their judgment, might have adverse effects on the well-being of the people.

Furthermore, our companies have taken an active part in making available voluntary plans to prepay costs of hospital and medical care and have had long experience in related insurance matters. They have therefore accumulated a very valuable fund of information with respect to practices and problems involved in the whole field of health insurance.

The life insurance business, as part of the American economy, is also deeply conscious of the importance of the economic effects arising from the proposed measure. Will it give rise to inflationary prices, thus diminishing the purchasing power of the dollar benefits promised under our various policies? Will it through the added tax burden slow down the initiative and productiveness of industrial and business activity and thus lower the standard of living?

It is the considered judgment of the life insurance business that the financial health of the Nation must receive its full share of consideration in any question which involves a very great expenditure of the people's money, garnered through taxes, and the future commitment of the public credit.

The proposal embodied in title VII of S. 1679 has become generally known as compulsory health insurance. In operation, as well as in philosophy, it represents a radical departure from the traditional American system of providing medical care. In discussing it, however, I shall confine myself to the portions of that subject which are most closely related to our experience.

THE STATUS OF THE NATION'S HEALTH

We are all in favor of good health. That is beyond question. We all want necessary medical care. We all want a continuation, or even an acceleration, of medical research which has conferred such amazing benefits on us, particularly in the last few decades.

The question is, How are these to be best obtained? What are the present difficulties in obtaining them? Can these difficulties be removed by a program of compulsory health insurance without creating other difficulties of serious moment?

It is the conviction of the life-insurance business that such a far-reaching step as is contained in title VII of the proposed legislation should not be taken unless supported by clear and overwhelming evidence that health conditions in the Nation are so critical as to require it, and that there is no other recourse.

In our considered judgment no such evidence has been produced or can be found in an examination of the facts in the case, and the step should not be taken.

Let us look at the record. What is the current status of the Nation's health?

A survey of the facts is reassuring. There is no health crisis. Rather, the story is one of progress on many fronts, in many respects approaching the remarkable. There are problems, true, but not of a character to justify radical action or tampering with a system of medical and health care that has so much solid achievement to its credit. To attempt to magnify the problems to the proportions of a crisis is unwarranted by the facts.

Here are some of the high lights of the record of achievement with respect to health conditions in the United States in recent years:

1. The over-all death rate in the United States has been reduced by more than 40 percent since 1900. If allowance is made for the higher proportion of older people in the population now than 50 years ago, then the death rate has been cut almost in half since the turn of the century. To put these figures in another way, we are now saving one and one-quarter million lives a year due to our progress since 1900.

2. The average life span has nearly doubled since the Republic was founded and has increased by more than a third in the last half-century alone. Currently, the average expectancy of life is around 67 years as against little over 49 years at the turn of the century and only 35 years at the beginning of the Nation.

3. Of the record crop of nearly 4,000,000 babies born in 1947, more than half will be alive at the age of 72 based on present mortality conditions. If mortality conditions prevailing at the beginning of the century were continued in effect, only one-half would be alive at the age of 58.

4. The rate for infant mortality has been reduced more than one-half and the rate for maternal mortality has been reduced four-fifths in the last 20 years.

5. The following diseases, once potent scourges, either have been virtually wiped out or mortality from them has been reduced by 80 percent or more since 1900: scarlet fever, whooping cough, diphtheria, measles, pneumonia, influenza, diarrhea, enteritis, tuberculosis, malaria, typhoid fever, and smallpox.

This is not the stuff from which a health crisis can be made. As the Brookings Institution sums it up in its recent study, "The United States is now among the most healthful nations of the world."

A dramatic example of life conservation is provided by an authoritative study made public recently by one of our life insurance companies.

This study shows that over a quarter of a million lives were saved in the year 1947 alone because of the improvement in mortality since 1940, a period of only 7 years. The total number of deaths would have been 1,712,000 in 1947 if the 1940 mortality rates had prevailed. The actual number of deaths in that year was 1,445,000, a saving of 267,000 lives.

Our medical schools, our doctors and our hospitals deserve much of the credit for this record of achievement. So do the many voluntary agencies working in the health field, most of them at the local level. Fullest commendation is also due to our public health authorities—municipal and State as well as Federal. Working together, our various medical and health-care facilities have constituted a most effective team.

FINANCING THE COST OF MEDICAL CARE

Let us now leave the results in the field of health and look at another important phase of the whole problem, namely, the financing of medical care. The cost of medical care has increased, due to the inflationary conditions of recent years, the improvements in the techniques of medical practice and our higher standards of medical care. The great majority of our people have had reason to fear the financial consequences of extensive medical care, especially surgical and hospital care, and today consciousness of the desirability of some financial protection is widespread.

It was for this reason that our Blue Cross organizations arose, starting in 1930. Incidentally, this history is an excellent illustration of the way in which the American people through voluntary action meet their own problems. Starting from scratch, these Blue Cross plans have now enrolled over 31,000,000 people. The gain in 1948 alone was 3,500,000.

Meantime the insurance companies, which had been so active in furnishing group life insurance, group pension plans, and group accident and sickness weekly benefits, recognized the additional desirability of financing the hospital care of employees by making group hospitalization insurance available starting in 1934. In the last few years an appreciable amount of this type of insurance has also been put into effect through consumer-sponsored organizations, labor unions, and other plans. As a result of all these voluntary efforts by Blue Cross, insurance companies, and others, there are today an estimated total of 61,000,000 Americans insured against the cost of hospital care, an increase of 8½ million in a single year.

If all this can be done in the short span of 18 years, should we destroy the whole structure of voluntary effort, which promises so much, in favor of a plan of Government regulation which contains the possibility of far-reaching unfavorable consequences and great dangers for the quality of our medical care?

Shortly after insurance plans had been inaugurated for protection against the cost of hospital care, the insurance companies began in 1938 to make available group insurance to meet surgeons' charges. Blue Shield organizations were soon started for the same purpose closely associated with the Blue Cross. In the few years which have elapsed up to the present about 34,000,000 people have been insured by all the types of organizations in this field. The gain in 1948 alone was nearly 8,000,000.

What about the costs of general medical care not involving either surgery or hospitalization? That is the newest and most experimental of all the recent plans of insurance and our experience to date has uncovered new and baffling problems not encountered in other forms of health insurance. Nevertheless it is showing rapid growth, and about 13,000,000 people are already insured against some costs of that nature.

We recognize, of course, that there still is room for growth in these voluntary efforts both in the scope of coverage provided and in the number of persons covered. The rapid growth of recent years has laid a foundation which promises a very wide coverage of the American public by voluntary insurance, if such voluntary insurance is not destroyed as it would be by this bill. We need to keep in mind that providing health coverage on a sound basis—no matter who provides it—requires certain inevitable limitations and involves many problems. Satisfactory solutions to some of them have been developed as is demonstrated by accomplishments thus far. Others are being explored or remain to be solved. Through hundreds of companies and agencies engaged in making such coverage available, experimentation of a most desirable and necessary sort is actively being pursued. This strikes us as the most effective means for assuring future growth and improvement.

Title VII of the bill is headed "Prepaid Personal Health Insurance Benefits," and many proponents of the proposal appear to maintain that it is simply a compulsory insurance scheme and not "socialized medicine." Let us, therefore, look for a moment at some of the characteristics necessary for insurance principles to be workable. Among the necessary elements is the primary one that the occurrence of the contingency insured against shall, for all practical purposes, be beyond the control of the insured. Obviously, too, the costliness of the benefits to be received upon occurrence of the contingency should not rest upon the voluntary choice of the person insured.

This bill certainly does not conform to such principles, since it contains a blanket promise of all types of medical and other services at the voluntary call of each person insured. Whether attention is required, what kind, and how much, would seem to lie largely with the individual. It seems very clear that when the restraints that normally exist are not present there will inevitably be a marked increase in the volume of services demanded and an inevitable tendency to use the more extensive, rather than the more simple, type of service when a choice is available—quite apart from the true need. The net effect would be that the aggregate costs of the scheme would become very largely uncontrollable. It is unrealistic to expect that the doctors can supply the necessary financial control when taxes have been paid giving the insured person a right to call for service. Nor is it reasonable to expect that Government employees would or could satisfactorily exercise such control. This lack of effective restraints places the scheme beyond recognition as a workable insurance plan.

One other practical insurance point should be considered. The small, routine costs of medical care, as distinguished from the heavy expenses of a major illness or accident, are foreseeable and can be budgeted in the same way that we budget other living costs, such as food and clothing. They would account for a major portion of the expenses of administering the proposed program without bringing any appreciable benefit to the individual. Possibly the workable answer for a broad application will ultimately be found in a restricted form of voluntary insurance which does not relieve the insured person of paying for the minor costs of general medical care, but takes care of necessary extensive medical care. About the last thing to do now, in the judgment of the life-insurance companies, would be to open the floodgates to all the problems and abuses that can come up in this field by adopting a Government plan containing no restrictions whatever with respect to its application.

In contrast to the proposed Federal compulsory plan, voluntary insurance plans are diverse in origin and sponsorship. They are, therefore, competitive and experimental, and hence dynamic and progressive. Because they must remain solvent, they conform to sound insurance principles while providing the social benefit sought. In contrast, provision for medical care on the proposed Federal Government model is monopolistic as well as compulsory. The principle of competitive selection between plans is discarded and voluntary choice is abolished. No voluntary plan could possibly survive, anyway, against the competition of benefits of the blank-check variety backed by what has unfortunately come to be regarded as a bottomless public purse.

THE ECONOMIC FACTORS

With respect to the whole question of financing the cost of medical care and the economic factors involved, it is most unfortunate from every respect to find the notion so widely prevalent that governmentally provided medical and health services would be "free." The program as envisaged in the proposed legislation is to pay for hospital and medical care through taxes. And taxes must come from the people and the productivity of the economy. There is no other source of funds.

As we understand it, the financing of the current proposal would work out as follows: Pay rolls of every business enterprise, small as well as large, would be taxed 3 percent except for wages in excess of $4,800 a year, half to be paid by the employer and half by the employee. The employer would find his costs of operation increased by 1½ percent of such pay roll. It seems certain that much of this increase in expense will find its way into prices, and the general public, largely composed of people of moderate or small income, would thus be taxed indirectly through increased prices. The employees' take-home pay would be decreased by 1½ percent, so they would have that much less money with which to pay the increased prices.

Then there is the unknown amount of general taxes—the Government's contribution to the program from general revenues—which would have to be raised for the balance of costs of the benefits in the proposal. This could easily be several billions of dollars. In addition to personal income taxes, it can be expected that much of this extra tax burden would fall on business and thus further inflate prices for the mass of the people to pay.

This type of wholesale tax action on every business concern, no matter how situated, not only has a price-raising effect, but it can also make it more difficult for small and medium-sized enterprises to remain in business. Thus the question is not that of money alone but of the welfare of millions of people, workers as well as employers, and of the stability and progress of the economy as a whole.

In connection with the economic consequences of the proposed program, it must be remembered that good health has many ramifications. Medical care is very important, of course, but good health and the avoidance of ill health are also dependent on many other factors, such as sanitary housing, adequate food, opportunities for healthful recreation, social and economic factors, and to no small extent even our personal willingness to take proper care of ourselves.

In essence, our whole standard of living is involved in this question of good health. With the multiplicity of taxes which now confront any and every business undertaking, it is a serious question of how much further we can go in adding on burden after burden without bringing on enough break-downs in our structure to jeopardize our high standard of living. If that should happen, there is little use of talking about expanded medical care, better housing or more of anything else that contributes to good health.

Estimates have been current that the proposed legislation for compulsory health insurance would cost $6,000,000,000 a year. That figure is doubtless too low. Some estimates run to double that amount.

The cost is very uncertain. It depends on a large number of factors, not the least of which is the amount of unnecessary medical care which would be demanded as a matter of right.

Experience abroad indicates the difficulty of accurate prediction with respect to the cost of health services under Government control paid for by taxes. In Great Britain, for example, it is a matter of record that the cost of the British program was underestimated by fully 40 percent for the first 9 months of its operation which started in July last year. And official figures for New Zealand show that the cost of its health benefits have increased at a marked rate year after year and rose nearly 50 percent in the last 5 years alone. The New Zealand experience is of particular interest since compulsory health insurance has been in effect there for 10 years; and it might thus be expected that the cost of the medical and health care benefits would have become reasonably stabilized after the first few years. Instead, the costs have continued to climb.

Thus all the evidence indicates that the financial burden of a compulsory health-insurance system would be very great on the American people and on the economy. Can the Nation afford any new burden of such dimensions, and such potentially far-reaching consequences, when the over-all cost of Government in the Nation is already so high—well over 25 cents of every dollar of national income, according to the latest figures? When the Federal Government itself is again running a deficit in its budget? When the public debt stands at $252,000,000,000, equivalent to $1,700 for every man, woman, and child in the country? And when the Nation is committed to such future obligations as the old-age and survivors insurance program which, on the liberalized basis now being considered by Congress, will alone cost anywhere from 13 to 20 billion dollars a year, according to official estimates, in the lifetime of the majority of today's children?

Questions such as these, all so intimately related to the financial health of the Nation, cannot be lightly dismissed; more especially since they have such a direct bearing on the progress of the economy, on our standard of living, on the future value of the dollar, and on the buying power of the people's savings in the years to come.

EVIDENCE FROM GREAT BRITAIN AND NEW ZEALAND

From abroad comes first-hand evidence of the impact and consequences of governmentally provided benefits like those proposed under a program of compulsory health insurance.

Sir Stafford Cripps, British Chancelor of the Exchequer, in discussing the 1949–50 budget in the House of Commons in April, had this to say:

> When I hear people speaking of reducing taxation, and, at the same time, see the cost of social services rising rapidly, in response very often to the demands of the people, I sometimes rather wonder whether they appreciate to the full the old adage that "we cannot have our cake and eat it."
>
> The social services have resulted in a very great and highly desirable redistribution of wealth at the expense of the more well-to-do for the sake of the less well-to-do * * *. But we must recognize the unpleasant fact that these services must be paid for, and that they must be paid for by taxation, direct and indirect.

> Total taxation, local and national, is now more than 40 percent of national income, and at that level the redistribution of income entailed in the payment for social services already falls, to a considerable extent, upon those that are the recipients of these services.
>
> We must, therefore, moderate the speed of our advance in the extended application of the existing social services to our progressive ability to pay for them by an increase in our national income. Otherwise, we shall not be able to avoid entrenching, to an intolerable extent, upon the liberty of spending by the private individual for his own purpose.

And corroborating evidence comes from the much older experience of New Zealand with compulsory health insurance. The annual report for 1948 of the New Zealand Director-General of Health contained this statement:

> It seems to be forgotten by too many of our people that health services as organized in New Zealand are a form of insurance against sickness and ill health and that, whatever form or measure of service is demanded, it must inevitably be paid for, however indirect the payment may be.
>
> All too frequently one hears the statement that so much tax is being paid, and that it behooves everyone to get as much in return as possible. This attitude undoubtedly accounts for many trivial and unnecessary calls on medical men and for much unnecessary prescribing and wastage of medicines. No social measure can succeed where there is a lack of social conscience.

Such testimony is illuminating in two major respects. For one, it dissipates any notion that the benefits of a compulsory health insurance program would be free. Then again, it gives an insight into how a system based on Government paternalism tends to undermine the self-reliance, the will, and the moral fiber of a people.

For the reasons brought out the life insurance companies believe deeply that the proposal in title VII of S. 1679 is unjustified by the facts, unnecessary in the light of the development of voluntary prepaid medical care, and fraught with unforeseen consequences to the quality of our medical care and to the American economy.

Thank you, sir.

Senator MURRAY. I suppose that your organization must have expended a great deal of time in preparing this statement, it must have required a great deal of study and thought on your part.

Mr. MURPHY. We gave it a great deal of study and thought, sir.

Senator MURRAY. Have you prepared this statement by yourself, alone?

Mr. MURPHY. No, sir; we have all of us prepared it together.

Senator MURRAY. A number of you prepared it together?

Mr. MURPHY. Yes, sir.

Senator MURRAY. Did all the insurance companies participate in it?

Mr. MURPHY. We were representing the insurance companies.

Senator MURRAY. What companies? All of the insurance companies?

Mr. MURPHY. The insurance companies that belong to the American Life Convention and the Life Insurance Association of America.

Senator MURRAY. I am sure you would not expect me or anyone to be able to sit here and listen to your reading of the statement and analyze it and discover the defects that may exist in it, would you?

Mr. MURPHY. Well, I do not know, sir. I do not believe I can answer that question, from your viewpoint.

Senator MURRAY. You would not expect anybody to listen to a statement of this character and be able to analyze it without having had a previous opportunity to study it and discover its possible defects, would you?

Mr. MURPHY. We would be very glad to have the statement studied. We hope it is studied.

Senator MURRAY. Yes, of course, and it will be studied.

You made a study once before of the effect of social insurance in this country, did you not—by "you" I mean the insurance companies.

Mr. MURPHY. Yes.

Senator MURRAY. And at that time you thought that it was a very dangerous thing?

Mr. MURPHY. You mean the old-age and survivors' insurance, sir?

Senator MURRAY. Yes.

Mr. MURPHY. Mr. Linton made a presentation of that, if that is what you mean.

Senator MURRAY. I do not know who it was, but my understanding is that the insurance companies at one time were very fearful of the effect of the social-insurance program.

Mr. MURPHY. Mr. Linton's position was not just one of opposition, sir. It was one of making suggestions as to the details of it, and not of opposition.

Senator MURRAY. My understanding is that the statement was made at that time, that it was a dangerous undertaking, and that it would have dangerous consequences.

Mr. MURPHY. I think, sir, if you look at the record, you will find that it was the extent and manner of doing it which was under discussion.

Senator MURRAY. Well, it was carried out substantially as it was planned; and at the time your idea was that it was an unwise procedure and that it was not necessary.

Mr. MURPHY. I think if you will examine the record, you will find, sir, that is not a correct statement of the position.

Senator MURRAY. Now, of course, as you say, you would like us to make a study of this statement and make an answer to it, and I suppose that will be done in due course.

On page 7 of your statement here you say at the bottom of the page:

> Whether attention is required, what kind, and how much—

and I guess you are talking here about the blanket inclusion of all types of medical services for each person insured.

Mr. MURPHY. Yes, sir.

Senator MURRAY (reading):

> Whether attention is required, what kind, and how much, would seem to lie largely with the individual.

Mr. MURPHY. Yes, sir.

Senator MURRAY. You further say:

> It seems very clear that when the restraints that normally exist are not present, there will inevitably be a marked increase in the volume of services demanded and an inevitable tendency to use the more extensive rather than the more simple type of service when a choice is available—quite apart from the true need.

Mr. MURPHY. That is right.

Senator MURRAY. You think that under this system the individual would determine the character and extent of the medical services?

Mr. Murphy. Very largely, sir, yes. I may quote you one illustration of that. When the Blue Cross in New York was started, with regard to the maternity benefits there was no limitation on the extent of hospital care. The general coverage was 21 days for full hospital care, with some partial extension after that.

They found that under those circumstances the average stay for maternity cases increased vastly and without apparent medical necessity. The consequence was that in order to even keep the plan sound and solvent, they had to alter the restriction on maternity benefits in part, to where they allowed a straight $80 benefit.

There are things of that sort that come into your experience; where there is a choice you cannot expect—particularly when people have paid taxes that give them the right—you cannot expect that they will not demand as much service as they feel they desire.

And, as we have said here in the statement, it is rather unrealistic to expect that the doctors will be able to control a situation of that kind.

Senator Murray. But under this bill, my understanding is that the character and the extent of the medical care is in the hands of the doctors.

Mr. Murphy. Sir, my point is that the doctor is not able to, as is illustrated by that one example I just gave you. He is not able to, as against the wishes of the person, to control a situation of that kind—it is just unrealistic.

Senator Murray. The doctor would not pay any attention to the actual facts in the case, but he would be guided entirely by the wishes of the patient; is that it?

Mr. Murphy. Well, here is a patient who says, "I pay taxes, so by paying taxes, I get this right."

Senator Murray. I know, but I am not asking you about that. I am asking you to answer my question.

Mr. Murphy. Yes, sir; I hope I did.

Senator Murray. You think it would be entirely in the hands of the patient to determine the character and extent of the medical services?

Mr. Murphy. Not entirely, sir.

Senator Murray. And you think since he is paying for it he would be entitled to demand services that would be unnecessary.

Mr. Murphy. To a considerable extent. Please do not misunderstand me, I do not mean that all the medical care that would be demanded would be unnecessary.

Senator Murray. Is it not true that hospitalization has always been in the hands of the doctors, and they have controlled the extent of hospitalization, and is it not further true that they have changed that considerably, taking your illustration of maternity cases as an example? There was a time when in maternity cases they kept them in the hospital for long periods of time but later they discovered it was not a wise procedure and the doctors determined it was much better to get them out of the hospital quickly?

Mr. Murphy. My I refer to a publication from the Public Health Director of New Zealand?

Senator Murray. New Zealand is not before this committee just now. I am talking about this present bill.

Mr. Murphy. The reason I said that is it is the same principle as involved in this statement.

Senator MURRAY. Well, we will determine that when we analyze the New Zealand provisions. There has been a lot of propaganda about the New Zealand services and the British services, and most of it is untrue.

Mr. MURPHY. That is the reason I quoted from the New Zealand official, so it would be authoritative.

Senator MURRAY. Well, is it not true, as I stated, that the period for hospitalization has been under the control of the doctors in this country and has changed radically?

Mr. MURPHY. I cannot answer that question. I think you will have to ask the medical profession, by and large—but there are margins of——

Senator MURRAY. No, I do not think you have to ask that question of any professor or any expert. The people of this country know it themselves, from their experience, that it is a fact.

Mr. MURPHY. They can control it to a considerable extent but the point is, and it comes into the counting of the cost, that there are these marginal situations that enter into it that you cannot control, and they enter into the cost.

Senator MURRAY. You have mentioned the British system in your statement a little while ago. That system has about 90 percent of its cost paid from the general revenues. Our program would have more than 75 percent of the cost paid for through insurance, and less than one-fourth from the general revenues. There is that distinction between the British system and the American system, is there not?

Mr. MURPHY. I cannot answer that question.

Senator MURRAY. You say on page 11 of your statement:

> Estimates have been current that the proposed legislation for compulsory health insurance would cost $6,000,000,000 a year. That figure is doubtless too low. Some estimates run to double that amount.

Who has made an estimate it would run double that amount?

Mr. MURPHY. It appeared in the Christian Science Monitor, I think in May, and it was made by Dr. Elizabeth Wilson, who has devoted a great deal of her time to social-security measures.

Senator MURRAY. She was one of the doctors opposing this bill on the pay roll of the National Physicians Committee, was she not?

Mr. MURPHY. She was? I do not know. However, it would seem to us, speaking in the over-all, where you have a bill that provides not only all the ordinary medical care but dental care, home nursing, and so on, that just, shall I say as the curbstone opinion, that if you are going to cover maybe 120,000,000 people, just offhand $6,000,000,000 looks like a very, very small figure.

Senator MURRAY. In your statement you also say:

> It depends—

speaking about that estimated figure of cost—

> on a large number of factors, not the least of which is the amount of unnecessary medical care which would be demanded as a matter of right.

Mr. MURPHY. Yes, sir.

Senator MURRAY. And that is your assumption, is it, that the ordinary individual would not pay any attention to the doctors advice but would demand a certain character of medical care and medicine, and so forth, that he would not need?

Mr. Murphy. That is overstating my position, but there is sufficient——

Senator Murray. You seem to say that here.

Mr. Murphy. There is a sufficient margin of cases, as I said about hospitalization, where they can go on, and it is extremely difficult, if not impossible, for the doctor to control.

Senator Murray. You have a quotation in your statement from Sir Stafford Cripps:

> The social services have resulted in a very great and highly desirable redistribution of wealth at the expense of the more well-to-do for the sake of the less well-to-do. * * * But we must recognize the unpleasant fact that these services must be paid for, and that they must be paid for by taxation, direct and indirect.

Of course, that is absolutely true, but in this bill of ours the people themselves are paying the large share of this cost for medical care.

Mr. Murphy. The people as a whole, of course, must pay whatever it costs. There is no other place where it can come from.

Senator Murray. They are paying for it now, are they not?

Mr. Murphy. Not what is promised in this bill, sir.

Senator Murray. What was that answer?

Mr. Murphy. They are not paying now necessarily what is promised in this bill.

Senator Murray. No. We are going to expand it, of course.

Mr. Murphy. I mean the expansion of services, whether necessary or unnecessary, that are contemplated in this bill.

Senator Murray. At any rate, the people are paying for medical care now, a very large amount, estimated as being somewhere around $5,000,000,000 a year.

Mr. Murphy. I do not know what the total is.

Senator Murray. That is about the total, and the people are paying it, and the expectation is that it will be increased because of the expansion of the care and the fact that a lot of people who are not now receiving adequate medical care would be able to receive it.

Now, would that not have an effect of reducing the taxes of the country, by reason of the fact that it will be administering to the health and care of people not getting it now, thereby increasing their productivity and thereby also increasing the productivity of the whole economy and benefiting the whole country?

Mr. Murphy. In our opinion, it would not be at all commensurate.

Senator Murray. Not commensurate. You think this story that people are not getting adequate medical care now is not true?

Mr. Murphy. Not true in a big way, sir.

Senator Murray. Not true in a big way, you say.

Mr. Murphy. For example, I mean, our needy people today are receiving—but as a matter of relief, they are receiving tremendous amounts of medical care which they need.

Senator Murray. We are glad to have your statement here, and we will give it very careful consideration.

Mr. Murphy. Thank you, sir.

Senator Murray. Our next witness this morning is Dr. William J. Stickel, executive secretary of the National Association of Chiropodists, Washington, D. C.

STATEMENT OF DR.. WILLIAM J. STICKEL, D. S. C., EXECUTIVE SECRETARY, NATIONAL ASSOCIATION OF CHIROPODISTS

Dr. STICKEL. Mr. Chairman and gentlemen of the committee:

The National Association of Chiropodists wishes to express opposition to Senate bill 1679 in its present form. In our opinion the field of foot health has not been given sufficient attention in the provisions of this proposed legislation. According to an estimate released by the United States Public Health Service, 90 percent of the population in this country is afflicted with some type of foot disorder. Surveys conducted by the National Association of Chiropodists and other interested organizations indicate that this alarmingly high figure is substantially correct. Several surveys made during the past 5 years have shown that 82 percent of the school children in the United States are afflicted with foot ailments, from minor to very severe degrees.

In view of these facts it is the opinion of our organization, comprising 7,200 chiropodists, who specialize in the care of the feet, that greater strees must be placed on the need for prevention and treatment of foot disabilities.

We, therefore, suggest that this bill, S. 1679, be amended as follows:

Page 104, part B, benefits and eligibility, classes of personal health services, line 21, paragraph (c), include after "Dental services" beginning on page 105, line 3, the following:

> Chiropody services consist of (1) general chiropody services rendered by a chiropodist in the general practice of chiropody, including preventive and diagnostic and therapeutic care, and periodic foot examinations; and (2) specialist services rendered by a chiropodist who is a qualified specialist in the class of services rendered, whether it be foot surgery, foot orthopedics, physical therapy, or chiropodical roentgenology.

We trust that the members of this committee will give favorable consideration to this suggested amendment.

Senator MURRAY. There are several other bills pending here, Doctor. Have you any familiarity with them?

Dr. STICKEL. Yes, Mr. Chairman. We have studied those bills to some extent and our general attitude is that which we have expressed in this. We feel that foot care has not been sufficiently emphasized in any of them. We have been relegated in two of the bills into a class of auxiliary services that simply does not give us enough opportunity to render the right kind of service, and the same is true in this present bill.

Senator MURRAY. Well, we are glad to have your suggested amendment, Doctor. I suppose that you would expect, if any of the other bills were being considered by the committee, to introduce this amendment for consideration?

Dr. STICKEL. We would appreciate it, sir.

Senator MURRAY. Thank you, Doctor.

Senator MURRAY. Our next witness is Alson J. Smith, of the Methodist Federation for Social Action.

STATEMENT OF REV. ALSON J. SMITH, METHODIST FEDERATION FOR SOCIAL ACTION

Reverend SMITH. Senator Murray and members of the committee, in the interest of time I would just as soon summarize the statistical section of this.

Senator Murray. You may.

Reverend Smith. I presume that those statistics are familiar to everybody, and so I will simply skip over the parts that deal with the total cost of sickness and disability and numbers of physicians in practice, and so on.

Senator Murray. Yes.

Reverend Smith. The statistics, all of them, seem to indicate to our organization that there is a definite need for a national health insurance program, and we would disagree with certain authorities who claim that the health of the Nation is excellent. We believe that there is room for great improvement.

One thing that concerns us is the fact that the big cities tend to have more than their share of doctors under the present set-up. I myself lived in one of those places for 2 years, in Granite County, Mont. The county had a population of approximately 4,000 people scattered over an area about the size of the State of Rhode Island.

There was one physician, and no hospital at all. The nearest hospital facilities were at Missoula, 85 miles away, where the Northern Pacific Railroad maintained a hospital, and for a simple thing like a tonsilectomy I had to travel 85 miles to Missoula and back, and anybody in Granite County who needed hospitalization, who had an emergency and needed to go to the hospital, had to travel that distance. There was no alternative, simply nothing else to do. And often there were no beds available at the Northern Pacific Hospital.

And, as I say in this document, I officiated at more funerals during my 2 years at Phillipsburg, Mont., than I have in all the rest of my ministry put together.

Senator Murray. I am very familiar with all that locality and that same condition could be found in other sections of the State, as well as some other western States.

Reverend Smith. I think that is true.

With all due respect to the private and voluntary plans, we believe that the voluntary plans are all right as far as they go, but they simply do not go far enough. They do not cover enough people. At present, some 27,000,000 have hospitalization insurance combined with physician's services in hospitals, and another 27,000,000 are covered for hospitalization insurance alone. But only about 3,500,000 persons are covered for anything approximating comprehensive care, including home and office care from physicians as well as hospitalization and physician's care in the hospital, according to the Committee on Research in Medical Economics.

Voluntary health insurance, as practiced at present does not cover even the major part of the subscriber's annual sickness bills. Hospitalization insurance, such as the Blue Cross, covers only 21 percent of an average family's annual medical bill. Add physician's services in a hospital, as in the Blue Shield plan, and it still remains relatively low—only 35 percent. Moreover, these plans make no provision, or inadequate provision, for preventive medicine.

We believe that S. 1679 is preferable to any of the voluntary plans. Without disparagement to the other bills, we believe that the national health insurance and public health bill—S. 1679; H. R. 4312; 4313—is the one best suited to this end. It is an integrated, comprehensive plan which provides for the problem of medical education and education in allied fields—dentistry, dental hygiene, nursing, public health, and engineering—and for medical research at the same time that it provides aid for rural and other shortage areas, assistance to farmer's health cooperatives, aid to States for public health work, maternal, child health, and crippled children's services. In addition to this it provides for a system of national health insurance that will cover approximately 85 percent of the population with free choice of doctor or dentist by the patient. We believe that this is a good bill, and a good over-all plan.

One feature of this bill which appeals particularly to us is that it does not entail any sort of a "means" test. Clergymen know better than most men how decent but impecunious people shrink from accepting anything that smacks of charity.

When I was pastor in Brooklyn I had in my church a good woman who had the misfortune to be married to a man who was a compulsive gambler. He left one job after another to follow the horses to Maryland and Florida, with the result that his family was hard put to it to live without assistance from the city. But they did, and were proud of it. However, this woman's health was not good. The local doctor recommended to her that she go to the hospital for a series of X-rays, and so on, but she refused on the grounds that she could not afford it.

I tried to get her to go to both the Kings County Hospital and to our Methodist Hospital in Brooklyn, but her answer was always a proud refusal to go to the county hospital as a charity patient or to the Methodist Hospital until she could pay her way. I am sure we all have a certain amount of admiration for that kind of sturdy independence. But today that woman's trouble was finally diagnosed as pelvic cancer and she has been told that she cannot live more than 6 months. Had she gone to the hospital when I first suggested it, and when the doctor urged it, she could in all probability have been treated successfully. But now it is too late.

The point is, a system of national health insurance such as is proposed in S. 1679 could have saved this woman's life, for there would have been no stigma of "charity" attached to help given under its provisions. I am sure that every clergyman knows of many similar instances. I believe it was St. Vincent De Paul who once said that "only because of your love will the poor forgive you for feeding them." Charity demeans the recipients; they do not like it and they do not like those who give it to them.

There is nothing un-American about compulsory health insurance. The underlying principle in the United States goes back to the days of John Paul Jones and Old Ironsides. In 1798 Congress established a compulsory health insurance plan for the new merchant marine. Industrial and fraternal health insurance plans, organized more than half a century ago, are still going strong. They are proof that national health insurance is as American as blueberry pie.

We believe that the majority of American churchmen support the idea of compulsory health insurance. Bishop G. Bromley Oxnam of my own church recently asked in a speech in New Jersey:

> Why should there be one doctor for each 597 persons in New York State and but one doctor for each 1,784 persons in Mississippi?

And the Reverend Francis W. McPeek, chairman of the legislative committee of the Council for Social Action of the Congregational-Christian Churches, recently stated that:

> We believe that the compulsory health tax plan * * * is eminently fair to all citizens as it is to all physicians * * * Christian social obligation requires that we see to the health of our neighbor, first because he is our neighbor, and, secondly, because his health, or ill-health, directly affects us.

We believe, too, that the value of a comprehensive plan of health insurance is being proved in Great Britain. Says the Lancet, a long established independent British medical publication:

> Both doctor and patient are pleased with their new and easier relationship * * * Patients are also grateful to observe that the new service is truly comprehensive * * * Complaints are few.

And even the Conservative Party, originally opposed to it, now promises the retention of the British Health Service Act should it be returned to power.

Senator MURRAY. I understand they are claiming to be the original sponsors.

Reverend SMITH. I understand Mr. Churchill is now making that claim.

The American voters would seem to be largely in favor of health insurance. A Nation-wide poll by the National Opinion Research Center in 1944 showed that 82 percent thought something should be done to help people to pay for medical care, and 85 percent thought social security should include doctor's services and hospital care. Governor Dewey's New York State Commission on Medical Care reported in 1946 that 84 percent of New Yorkers want health insurance. An impartial survey conducted by the Washington Post in 1946 revealed that 70 percent of Washington residents endorse national health insurance.

For all these reasons, then, our Methodist Federation for Social Action supports S. 1679, the National Health Insurance and Public Health Act. Thank you for this opportunity to testify for our organization in its behalf.

Senator MURRAY. I appreciate your statement, doctor. I have got so much propaganda against the bill that it is refreshing to have someone who has studied it and finds that it has some desirable features to it.

There has been altogether too much propaganda let loose in the country designed to discredit the bill without giving proper study to it at all.

When we first began to study this problem in the Senate, when we were talking about the insurance plan, at that time the American Medical Society even opposed voluntary insurance and thought that that would be a dangerous thing for the country. But when we finally began to get the people of the country to appreciate that some form of insurance was necessary and we proposed the compulsory system then they accepted the voluntary method and began to propagandize for it.

As you point out, a great many people are unable to avail themselves of the voluntary insurance type because it is too costly and has restrictions in it that make it impossible for many people to take that sort of insurance. So it seems to me that the program which we have here is a program that will meet with great success if it is put into operation and properly administered.

We appreciate your appearance this morning, and thank you very much for your statement.

Senator MURRAY. Our last witness for today is Dr. Albert Bailey of the American Osteopathic Association.

STATEMENT OF DR. ALBERT BAILEY, AMERICAN OSTEOPATHIC ASSOCIATION

Dr. BAILEY. Gentleman of the committee, I have a statement I wish to read—and I hope you will not consider it propaganda.

Senator MURRAY. I am sure we will not. What we want is testimony on both sides of this.

Dr. BAILEY. We have a few suggestions we would like to make. I have been chairman of our committee for 10 years, and I can say we have always kept an open mind on health insurance, and I do not think you will find any statement from our organization is being used as propaganda, because we like to keep our eyes open.

Senator MURRAY. Of course, I have reference to organizations created for propaganda purposes. Your organization is entirely different. I was talking about the national physicians committee, which was set up for the express purpose of carrying on a vicious propaganda against the proposal without having any basis for many of their statements.

You may proceed, doctor.

Dr. BAILEY. My name is Dr. Albert W. Bailey. I am an osteopathic physician engaged in the private practice of medicine and surgery in Schenectady, N. Y.

I have been chairman of the health committee of the American Osteopathic Association for 10 years, and for the past 4 years I have been speaker of the House of delegates of the American Osteopathic Association. We have had very wide discussions about the various compulsory forms. Your invitation to testify on S. 1679 is very much appreciated.

I appear here as chairman of the committee on health insurance of the association at the instance of the department of public relations which is charged with the duty of furnishing Congress pertinent information on subjects affecting the public health.

The American Osteopathic Association has a membership in excess of 8,000 out of a total of more than 11,000 physicians of the osteopathic school of medicine licensed and practicing their profession in all the States of the United States. The association is organized along democratic lines. The policy-making body is a house of delegates which meets annually, the delegates to which are elected by divisional societies in the respective States. The fifty-third annual convention will meet the week of July 11 in St. Louis. This convention will commemorate the diamond jubilee of osteopathy, as it was in 1874 that Dr. Andrew Taylor Still announced the principles which formed the basis of the osteopathic school of medicine. Eighteen years later, in 1892, Dr. Still established the first college of osteopathy in Kirksville, Mo., to "improve our systems of surgery, midwifery—which we now call obstetrics—and treatment of general diseases."

The primary objective of the American Osteopathic Association as stated in its constitution is "to promote the public health."

Manifestly, the osteopathic profession and institutions are concerned with any plans which may be projected by the Government affecting the private practice of the healing art and the health of the people generally, such as are proposed in the various bills now pending before this subcommittee. These bills will be considered by our house of delegates within the next 2 weeks. However, in view of the desire of your committee to complete hearings on these proposals without delay, we are prepared to submit such observations and suggestions as appear consistent with past decisions of the house of delegates on substantially similar bills.

At the outset I should like to comment on certain previous testimony. On June 21, 1949, a chiropractic witness gratuitously listed osteopathy as a "nonmedical" profession. In that connection, the witness was ill-advised. As I have already stated, the first school of osteopathy was organized to improve our systems of surgery, obstetrics and the treatment of general diseases, as a complete system of the healing art. Then and now misuse of drug therapy was condemned, but the emphasis which the osteopathic school placed and places on osteopathic manipulative restoration of structural integrity of the body was and is made in proper relation to the application of indicated chemotherapy and surgical procedures. During the war, osteopathic hospitals were designated by the Government as depots for the storage and distribution of penicillin and streptomycin.

In a dozen of the States, licenses to practice medicine and surgery are granted osteopathic graduates. In some 16 additional States osteopathic graduates are granted unlimited licenses to practice. Thirty-six States license applicants with the degree of doctor of osteopathy to practice obstetrics and major operative surgery. In 40 States, the District of Columbia and Hawaii, osteopathic physicans or surgeons qualify and register under the Harrison Narcotic Act.

Indicative of the comparable scope of training furnished in medical and osteopathic colleges, the Congress in 1929 in legislating for the District of Columbia provided:

> The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations. (That is section 12, Public Law 831, 70th Cong.)

Several State medical licensure agencies have made personal inspections of the osteopathic colleges and found them to be furnishing adequate training for their graduates to be admitted to State examination and licensure for the practice of medicine and surgery in all their branches.

The Administrator of Veterans' Affairs has made appointments of osteopathic applicants to the Medical Service of the Veterans' Administration, after investigation and approval of the osteopathic colleges and intern training hospitals pursuant to the provisions of Public Law 293, Seventy-ninth Congress, reading as follows:

> SEC. 5. Any person to be eligible for appointment in the Department of Medicine and Surgery must * * * in the Medical Service—hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator, and be licensed to practice medicine, surgery, or osteopathy in one of the States or Territories of the United States or in the District of Columbia. * * *

There are six colleges of osteopathy and surgery, all nonprofit and Federal income-tax exempt. All colleges require no less than 2 years preprofessional college education. The Bureau of Professional Education and Colleges of the association recommends that preosteopathic students complete 3 years' college work. An average of over 60 percent of osteopathic matriculants in 1947 and 1948 had completed three or more years preprofessional college work and most of that number had obtained baccalaureate degrees. The freshmen who entered osteopathic colleges in 1948 received their preprofessional training in colleges in 42 States, the District of Columbia, and three Canadian Provinces, and the 528 freshmen represented 236 liberal arts colleges and universities. The professional course in osteopathy and surgery extends over a minimum of 4 years. Graduates receive their intern training in 64 accredited intern training hospitals.

Now, I have brought out these facts in order that the finished product of this training, the osteopathic profession, may be viewed in the proper perspective of relationship to the health plans now pending before this committee.

The most comprehensive plan is provided in S. 1679. Under that bill virtually all employed persons and their dependents would be entitled gradually to complete "personal health services," such services to be rendered by persons who are authorized by applicable State law. With respect to medical services, the person rendering the service must also be a physician.

Now, apparently the question who is a physician is for Federal determination. That having been determined, the question would be whether he is authorized under the State law to provide the services involved.

If the bill should be enacted in its present form without a definition of the term "physician," it might be assumed that the Federal agency would be guided by other Federal legislative definitions of the term. It appears that Congress has defined the term "physician" only on one occasion, namely, in the United States Employees Compensation Act of 1916, as amended, reading as follows:

> The term "physician" includes surgeons and osteopathic practitioners within the scope of their practice as defined by State law.

That is from Public Law 558, Seventy-fifth Congress.

However, this assumption is diluted by the testimony of Acting Federal Security Administrator J. Donald Kingsley during the hearings now being held on a companion bill to your bill, in other words H. R. 4312, before the Subcommittee on Public Health, Science, and Commerce, of the House Committee on Interstate and Foreign Commerce. Asked whether the bill contemplates osteopathic physicians for the provision of medical services, Mr. Kingsley replied:

> It is vague in this sense that it provides that wherever they are licensed to practice medicine in a State then they are included, but where that is uncertain, as it is in a number of States, then the bill is uncertain.

Mr. Kingsley's statement adds to the ambiguity by introducing the consideration of the phrase "licensed to practice medicine in a State," which appears nowhere in the bill.

In the generic sense, medicine means healing art, and osteopathic graduates being licensed to practice the healing art in all States, would be accounted licensed to practice medicine in all States. If the term means expressly licensed to practice medicine, it would include osteopathic licensees in some dozen States only. If it should mean unlimited licenses to practice the healing art, it would then include osteopathic graduates in some 28 States only.

Obviously, the legislation should be amended to relieve that ambiguity by a specific definition of the term "physician" for the purposes of the act. Such a definition should leave no doubts that persons eligible for benefits under the act in all the States shall have choice of osteopathic graduates within the scope of license to practice as defined by State law.

In the absence of such a definition or Federal regulation to the same effect, I am advised that the act might be vulnerable to constitutional attack on the ground of denial of equal protection of the laws. Inasmuch as the legislation contemplates pay-roll taxes for the support of the program and creates vested rights for complete medical care, it would certainly seem denial of equal protection of the laws to guarantee choice of available services to the eligible patients of one school of medicine and then deny it to the eligible patients of another.

We have confidence that Congress will provide against any such dilution or jeopardy of the program, and therefore we shall proceed to other considerations.

Most osteopathic physicians are engaged in general practice; however, an increasing number are going into specialty practice. In connection with the specialties, there are American osteopathic certifying boards for dermatology and sypilology; for internal medicine; for neurology and psychiatry; for obstetrics and gynecology; for ophthalmology and otolaryngology; for pathology; for pediatrics; for proctology; for radiology; and for surgery. It is noted under section 711 that the qualifications of specialists are to be determined in accordance with the standards and certifications developed by such professional agencies as far as is consistent with the purposes of the act.

There are some 357 hospitals staffed by doctors of osteopathy with a capacity of some 8,039 beds. Under section 713 hospitals would qualify under State standards.

In that connection, it might be interesting to note that if we take the commonly accepted standard of about—or the average standard, shall we say, or the optimum standard of 5 beds for 1,000 population, that these slightly over 8,000 beds in these osteopathic hospitals cater to over 1,000,000 of our population. We break down the figures in that way.

S. 1456 and S. 1581 depend on voluntary prepayment plans. S. 1679 provides for agreements with voluntary health insurance organizations.

We have had some experience with Government agreements with voluntary health insurance organizations.

From 1936 until a few years ago the Federal Farm Security Administration sponsored farmers' health cooperatives and accepted positions on the boards of directors of some of them. In order to facilitate the organizations the Farm Security Administration entered into closed-shop agreements with the State medical societies restricting participation to doctors of medicine. The Government loaned money to needy farmers to pay the premiums and then made up the difference between the premiums and the actual costs of the services. Many of the farmers had family physicians who were doctors of osteopathy and were under the impression that their family physician was eligible to participate and that his services would be available to them under the plan. When they found out differently, they protested to Washington.

The Farm Security Administrator replied that participation was restricted to doctors of medicine because a majority of the farmers go to doctors of medicine, and, further, that the Government could not take the chance that the doctors of medicine would refuse to cooperate if any other dotcors were made eligible.

In other words, the majority determined the choice of physician for the minority under pressure of a prospective medical boycott. That put the needy farmer in the position of having to surrender his own choice of physician in order to obtain the Government subsidy for his medical services.

With a view to correction of the abuse the United States Senate on May 2, 1944, included a provision in the Agricultural Organic Act of 1944, H. R. 4278, limiting the application of the Farm Security funds as follows:

> *Provided,* That no part of such sums be available for the promotion or aid of any program of medical care which prevents the patient from having the services of any practitioner of his own choice so long as State laws are complied with.

The entire section dealing with Farm Security, including the above provision, was deleted from the bill before final passage.

Some such limitation, however, should be written into the bills now pending before this committee.

In a number of jurisdictions osteopathic hospitals are members of Blue Cross, and the numbers in that direction are increasing. Osteopathic physicians are not members of Blue Shield; they are limited to doctors of medicine alone, except that the State of Pennsylvania has recently enacted legislation requiring their eligibility.

An increasing number of State osteopathic associations have entered into agreements with the Veterans' Administration for furnishing home-town care for veterans with service-connected disabilities. In a few States the State osteopathic association and the State medical society utilize the same service agency for this purpose. Osteopathic physicians in all States are granted authorizations by the Veterans' Administration for rendering care for veterans in service-connected cases.

In conclusion, I wish to say at this time that it is and has been for the last 10 years the consistent policy of the American Osteopathic Association to offer active cooperation for the promotion and execution of any sound health plans instituted by Government or private sources, whether the plans be supported by voluntary or compulsory prepayments although preference has been expressed by the house of delegates several times for a single national prepayment plan supported by taxation, pay roll or otherwise, as affording the nearest to complete and comprehensive coverage.

This statement has been confined to the health insurance title of these bills now before your committee. We have submitted separate testimony on certain of the other titles.

With regard to S. 1106—I guess that is the Lodge bill—for furnishing high-cost diagnostic services and high-cost drugs for various diseases free to those who require them, our comments are already a matter of record before this subcommittee in connection with a similar bill of last Congress (see hearings on S. 678, 80th Cong.).

Thank you.

Senator MURRAY. Doctor, you say on the last page of your statement—

> * * * whether the plans be supported by voluntary or compulsory prepayments although preference has been expressed for a single national prepayment plan supported by taxation, pay roll or otherwise, as affording the nearest to complete and comprehensive coverage.

Was that position taken by the American Osteopathic Association as the result of resolutions adopted?

Dr. BAILEY. That was taken and reiterated for several years after we had considerable discussion in the house of delegates, of which I am speaker; and as a result of the discussion this resolution was put before the house of delegates and adopted, and this is quoted from that resolution passed by the house of delegates.

Senator MURRAY. Could you furnish the committee a copy of that resolution for the record in connection with your testimony?

Dr. BAILEY. Yes; I can furnish it from the excerpts of the minutes of the house of delegates when it was passed.

Senator MURRAY. If you will give it, we will put it in this record at this point.

(Resolution referred to is as follows:)

PROCEEDINGS OF THE HOUSE OF DELEGATES, AMERICAN OSTEOPATHIC ASSOCIATION—COMMITTEE ON HEALTH INSURANCE

9. In order to improve the public health by a comprehensive medical plan for wage earners the AOA favors the principle of a single national prepayment health system, provided that, before any specific health insurance legislation is approved or disapproved by the AOA or divisional societies, such plan shall be examined for substantial compliance with the 10 health insurance fundamentals adopted by the last three houses of delegates. Until some National, State or Territorial health act is adopted, the osteopathic profession will continue to cooperate with State plans, voluntary nonprofit, and other insurance plans providing they are comprehensive in nature, managed in the interest of public health, and are not controlled solely by any one school of practice.

(Board of trustees, New York, 1946, p. 156; house of delegates, p. 46: Reiterated, house of delegates, Chicago, 1947, pp. 40–41.)

Senator MURRAY. I wish to thank you for your statement. Your testimony has been very fair. I am very much interested in that part of your testimony where you talk about the discrimination against your profession.

If the Congress were to pass a bill giving subsidy to the voluntary system controlled by the medical societies, that would not be acceptable to your organization?

Dr. BAILEY. That would put a good many of us out of business.

Senator MURRAY. And if any such bill as that were being considered here, you would want us to take into consideration your recommendations?

Dr. BAILEY. If any serious consideration was given to a bill like that, we would practically have to have an amendment such as that on page 7, which says:

Provided, That no part of such sums be available for the promotion or aid of any program of medical care which prevents the patient from having the services of any practitioners of his own choice so long as State laws are complied with.

That provision is lacking in all the voluntary bills I have read to date.

Senator MURRAY. And without that provision your profession would be put out of business?

Dr. BAILEY. We believe so.

Senator MURRAY. You say you have six colleges of osteopathy in the country.

Dr. BAILEY. Six recognized colleges.

Senator MURRAY. Are any of them associated with any of the State or private universities of the country?

Dr. BAILEY. No. All our colleges have to stand on their own feet. We do not get any Federal or State grants. In fact, in that connection, our profession itself has put up $2,000,000 to support our own colleges, from our own doctors.

Senator MURRAY. I appreciate your statement, and I assure you it will have full consideration.

Dr. BAILEY. Thank you.

Senator MURRAY. We will meet tomorrow morning at 10 o'clock, and the witnesses at that time will be Senator Flanders, Congressman Pace, Congressman Javits, and Congressman Herter, who will all testify before us in support of the measures they are interested in.

Thank you very much, and good morning.

(Whereupon, at 11:23 a. m., an adjournment was taken until 10 a. m., Wednesday, June 29, 1949.)

NATIONAL HEALTH PROGRAM OF 1949

WEDNESDAY, JUNE 29, 1949

United States Senate,
Subcommittee on Health of the Committee
on Labor and Public Welfare,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., in the committee hearing room, Senator James E. Murray (chairman) presiding.

Present: Senators Murray, Pepper, and Donnell.

Senator Murray. The hearing will come to order, please. I understand Senator Flanders is unable to be present here at this moment, but it is expected he will be here very shortly. Therefore, we will call one of the other witnesses.

Mr. O'Connor, please.

STATEMENT OF EDWARD H. O'CONNOR, MANAGING DIRECTOR, INSURANCE ECONOMICS SOCIETY OF AMERICA

Mr. O'Connor. Mr. Chairman and gentlemen of the committee, my name is Edward H. O'Connor and I am appearing this morning on behalf of the Insurance Economics Society of America, an organization devoted to the study of all forms of social insurance. My home is in Chicago, Ill.

Senator Donnell. Mr. Chairman, would it be in order to ask Mr. O'Connor to develop for the record something about his organization, this Insurance Economics Society of America?

Senator Murray. Yes.

Mr. O'Connor. The Insurance Economics Society of America is an organization of companies principally interested in the sale of sickness and accident insurance.

Senator Donnell. How large an organization is it?

Mr. O'Connor. It is composed of about 86 companies, principally interested, as I just said, in the sale of sickness and accident insurance, all over the country.

Senator Donnell. All over the United States?

Mr. O'Connor. Yes, sir.

Senator Donnell. Did you want to examine him on this phase, Mr. Chairman?

Senator Murray. I will just ask him a few questions about it. What is the basis of your insurance? What is the character of the insurance you give?

Mr. O'Connor. They sell principally sickness and accident insurance.

Senator MURRAY. And do you accept anybody for insurance that comes along?

Mr. O'CONNOR. They go right from the industrial field, right up to the intermediate and commercial fields; we cover all grades.

Senator MURRAY. So that any person can apply for that insurance?

Mr. O'CONNOR. That is right, sir.

Senator MURRAY. Is there any limitation or any qualification that you demand before you insure a person, such as with reference to his health or physical condition?

Mr. O'CONNOR. You have your underwriting requirements on the application, except, of course, in group insurance. In group insurance there is no qualification.

Senator MURRAY. But there is on individuals?

Mr. O'CONNOR. On individuals, you have your underwriting requirements to be met by the applicant.

Senator MURRAY. And what are those requirements that have to be met by the applicant?

Mr. O'CONNOR. Certain physical requirements have to be met by the individual applicant.

Senator MURRAY. Is there any requirement as to the profession that they may belong to, or as to the occupation they engage in?

Mr. O'CONNOR. It would not make any difference, you have your classifications; you have your industrial privileges, and your intermediate and commercial, and you have your coverage to take care of them.

Senator MURRAY. If I were a miner in Butte, Mont., I could apply for insurance?

Mr. O'CONNOR. Yes, sir; or if you were a logger in the State of Washington, or engaged in any other occupation.

Senator MURRAY. There would be no limitation whatever?

Mr. O'CONNOR. Not on your occupation.

Senator MURRAY. And what about age?

Mr. O'CONNOR. There are certain age restrictions on new applicants; I would say 60 or 65. We are talking, Senator, about individual risks now, not group.

Senator MURRAY. Would that insurance continue as long as the man lives?

Mr. O'CONNOR. On the individual they stop at 70.

Senator MURRAY. I carried a policy for about 25 years, and when I reached 65, they threw me out.

Mr. O'CONNOR. You were too old.

Senator MURRAY. And so I never got any money out of it.

Mr. O'CONNOR. Now, they are trying to take care of that. They have a policy in which they carry them. But I remember that very well, where I had the duty many times to tell a man he was too old.

Senator MURRAY. It is getting modernized.

Mr. O'CONNOR. Yes, sir.

Senator MURRAY. Let me ask you this. Do you think this agitation that is going o nall over the country has had anything to do with modernizing the system?

Mr. O'CONNOR. It has not only modernized it, but it has made the people accident and sickness conscious; and it has helped the sale of policies.

Senator MURRAY. It has helped the insurance companies of America?

Mr. O'CONNOR. Very much, this agitation that we have had, and that is demonstrated if you look at the figures for premiums and policies.

Senator MURRAY. You ought to issue a full paid-up policy to me for the rest of my life. [Laughter.]

Do you want to ask any more questions?

Senator DONNELL. No, sir.

Senator MURRAY. You may proceed.

Mr. O'CONNOR. It is not my intention to discuss to any great extent the medical phases of the problem since you have had testimony submitted by individuals well qualified to deal with these aspects. I desire, however, to present to the committee some pertinent facts on the importance of voluntary insurance to the people of our country, the part insurance has played in our economy, and to correct, if possible, some of the wild and unfounded statements that have been broadcast during the past few years dealing with the number of individuals covered by and the supposed inadequate facilities of private voluntary insurance to do a proper job.

Since this committee is considering four bills dealing with a comprehensive health program, I will first direct attention to S. 1106 by Senator Lodge. This bill briefly provides public aid for only a few medical services of which some are already provided by State and voluntary agencies. This proposal would encourage the setting up of another State health agency, thus bringing a new organization into the scene. This no doubt would lead to duplication of work and raises the question whether a new agency is necessary and cannot this service be rendered by existing agencies?

S. 1456, S. 1581: These two bills attempt to accomplish a worthy objective—care for the medically indigent. However, in attempting to achieve what may be considered a laudable goal I do not believe we should ignore some practical considerations in developing the best system of providing and paying for the services rendered, which I think we will agree, can only be secured through wide competitive measures.

Both of these bills specifically direct the States to provide for the services by "voluntary medical, dental, or hospital insurance plans operated not for profit." This immediately removes private insurance from competing and rendering a function that has proven of inestimable value to the people of our country. The question may properly be asked: "Should the Government take an official position of preference in the voluntary insurance field?" Also the question may be asked: "Why limit the States in the manner in which they may provide these services?"

Insurance companies are writing a large volume of disability, hospital, and medical care insurance. We have mutual, assessment, and stock companies writing this business but under these two bills they would be excluded from participating. So-called nonprofit organizations would be encouraged and would eventually preempt the field. Since these organizations are local in character they would be entirely without competition, and in time would develop all of the weaknesses and faults that go with any monoply.

It is needless to point out that when goods and services are sought for in a free and competitive market the best in service, quality, and price results. When the Government wants to erect a building, or build a battleship or buy a flock of bombers the bidding is not restricted to one class of purveyors. In the field of subsidy—in which perhaps the mode of payment under these two bills may fall—the Government subsidizes private enterprise when it pays subsidies to farmers. Is not FHA and the GI loans a Federal subsidy of private enterprise? Why have any directive as to how the State shall provide the services as long as a State or community can meet the necessary requirements as laid down in the act? In this way the best will be obtained at the lowest cost.

It may be of interest for this committee to know that a number of insurance organizations writing group accident and sickness insurance are mutual companies, whose only stockholders are their policyholders and who receive the dividends.

Our mutual companies, or nonprofit companies—would they qualify under these two bills and, if so, would there be discrimination against those companies?

When you examine this picture closely you will find only a slight difference in the cost of doing business of these mutual companies compared with the so-called nonprofit insurance organizations. Furthermore the insurance business is considered semipublic. It is regulated rigidly by the States, it has developed numerous plans for improving the health of the people, and it maintains research organizations interested in national health. It can be integrated into State plans, as amply demonstrated in California and New Jersey, where you have State sickness-compensation systems, and where the insurance industry is doing an outstanding job in both benefits and costs. In California, for example, the private insurance-company plans average $5 more per week per claim than the State fund. In New Jersey private insurance companies now cover 50 percent of the risks. The same will be true in New York when that system goes into effect in July 1950.

Insurance companies are now successfully competing with Blue Cross and Blue Shield even though insurance companies pay a large amount in taxes which the nonprofit organizations do not pay. Insurance companies have a right to compete in this field where they have demonstrated they can give adequate service. Furthermore, I believe it is un-American to exclude any form of organization in what should be a competitive field.

In your deliberations, gentlemen, if you should come to the conclusion that either S. 1456 or S. 1581 should be enacted, by all means give due consideration to removing the directive as to how the State shall provide these services, and leave it open for fair competition which will result in the furnishing of all that is required at the lowest cost.

S. 1679: There is little disagreement as to the desirability of the wisest possible distribution and availability of the best quality of medical care. No one will question the motives to strive to accomplish this goal but differences of opinion arise as to the best way to attain this objective, and consequently I find myself somewhat in absolute disagreement to the modus operandi as called for in this bill.

I do not believe that anything by law should tear down what is already working well and which the people of this country are seeking in their quest for security in the event of accident or sickness.

From the insurance point of view we are faced with a compulsory approach versus the voluntary. There is no doubt about it, under voluntary insurance great strides have been attained in protecting the people of this country particularly during such a recent period as the last 5 years. In order to clear up misunderstanding regarding the position of voluntary insurance and the services it is rendering, in a survey about to be completed for 1948, it will show that 61,000,000 Americans are protected for the costs of hospitalization, 34,000,000 have protection for surgical benefits, 13.000,000 insured for medical care—a relatively new coverage—and 33,000,000 have loss-of-time protection in the event of accident or sickness.

Senator DONNELL. May I inquire?

Senator MURRAY. Yes.

Senator DONNELL. Under whose auspices is that survey being conducted?

Mr. O'CONNOR. By the various organizations in the trade, by the life and accident people; all those have gotten together to make that survey, and this is the second survey. The first one was completed in 1947.

Senator DONNELL. When will the survey be completed and available?

Mr. O'CONNOR. It ought to be out in about 60 days. These figures I just read are the advance figures, sir.

Senator DONNELL. What will be the name under which it will appear? I do not mean the title of the document, but the name of the organization.

Mr. O'CONNOR. It will be a survey issued by the Life Insurance Association of America, 165 Broadway, New York, N. Y. I believe the gentleman from there testified here yesterday.

Senator MURRAY. Could you tell us what percentage of the income your organization receives is paid out to members?

Mr. O'CONNOR. To policyholders?

Senator MURRAY. Yes; to policyholders.

Mr. O'CONNOR. Last year the receipts in the accident and health business—this is exclusive of nonprofit—was $1,200,000,000. The payments were a little over $800,000,000. That is all accident and sickness, exclusively.

Senator MURRAY. I see.

Mr. O'CONNOR. And that is on business written by your insurance companies, not nonprofit.

Senator MURRAY. All right, sir, proceed.

Mr. O'CONNOR. If you take the figure of 33,000,000 wage earners now insured in this country for loss of time due to accident or sickness, over 50 percent of the labor force, and compare that with the 37,000,000, and I am quoting Mr. Ewing from his article which appeared in the American magazine of last January, covered under unemployment insurance, a compulsory law, it is not hard to understand that in due time voluntary insurance will be successful in protecting as large a number of our people as is possible, bearing in mind that there will always be a certain percentage of individuals medically indigent requiring the services that are now provided for them. As an illustration I refer to a recent survey made in the State of Wisconsin by the unemployment commissioner which showed that 47 percent of the 60 percent of the labor force covered under unemployment insurance had some form of protection in the event of accident or sickness. In a survey made by a legislative committee in Illinois in 1946 they found 50 percent of the workers under the Unemployment Compensation Act covered either under paid sick-leave plans or group accident and sickness insurance. That figure today can be conservatively estimated as increased by at least 15 percent.

Senator DONNELL. If I may interrupt, is that 15 percent of the 50 percent?

Mr. O'CONNOR. Yes, sir; over and above.

Senator DONNELL. You mean, then, 57⅓ percent instead of 50 percent?

Mr. O'CONNOR. That is right.

Senator DONNELL. Thank you.

Mr. O'CONNOR. What is true in Wisconsin and Illinois will undoubtedly be true in many of our States.

This naturally leads to the question: "Why should action be taken on a proposal of this order until a proper survey had been made of the amount of protection now in force and of the health needs of the American people?" Why, gentlemen, proceed on suppositions and facts that may not stand up under close scrutiny? Perhaps such a survey might bring to light other different deficiencies which are more important than what you are attempting to accomplish under this bill.

Dr. Paul R. Hawley in his appearance before this committee on May 31 made such a recommendation. I second it and urge you to consider the creation of a commission, similar to the Hoover Commission, if you please, to make a bona fide study of the health needs of the country and to recommend to Congress the best means by which those needs could be met. Not enough thought and unbiased study has been given to the many problems involved in a national health program. Such a study should be made based on facts and realities, not on wishful thinking.

Under the voluntary methods now in vogue insurance plans meet the various local and regional differences, they allow for the adaptation of methods applicable to various problems, and of course they permit intensive competition which makes for the better product.

As an indication of the interest displayed by industry and the public in seeking protection against the costs of illness, a survey made in 1948 by the Research Council for Economic Security in six metropolitan areas, covering a total of 3,965 firms, employing 1,960,773 workers, with a 37.7 percent return from firms contacted, shows the following results—

I will not cover that, because it is in this table on the next page and I think it is self-explanatory. It gives the percentage of reporting firms and the percentage of employees by type of carrier, and then breaks it down by various groups of coverage.

Senator DONNELL. I would like, Mr. Chairman, to have that table in the record at this point.

Senator MURRAY. Yes.

(Table referred to is as follows:)

Percentage of reporting firms with plans, by metropolitan area

Benefit plan	Chicago	Minneapolis-St. Paul	St. Louis	Pittsburgh	Cleveland	Detroit
Prepaid hospitalization	84.1	81.6	76.8	83.2	77.3	71.0
Prepaid surgical benefits	55.9	32.0	38.7	42.5	29.5	61.3
Prepaid medical care	9.9	8.1	13.8	4.3	4.9	14.5
Organized cash sickness	41.2	23.8	20.9	32.1	25.9	33.5
Paid sick leave	42.7	36.0	36.7	27.5	42.3	32.0

Percentage of employees in reporting firms covered by plans in metropolitan areas

Benefit plan	Chicago	Minneapolis-St. Paul	St. Louis	Pittsburgh	Cleveland	Detroit
Prepaid hospitalization	76.6	68.5	70.6	66.9	69.0	68.3
Prepaid surgical benefits	49.9	32.8	41.6	38.5	33.1	62.8
Prepaid medical care	5.5	10.2	19.8	3.5	6.2	3.9
Organized cash sickness	55.9	41.0	48.2	50.0	47.2	69.7
Paid sick leave	21.3	30.1	22.8	17.7	25.9	21.4
Organized cash sickness or paid sick leave	69.3	55.0	60.5	60.8	58.4	75.4

Percentage distribution of employees covered by type of carrier

Carrier	Chicago	Minneapolis-St. Paul	St. Louis	Pittsburgh	Cleveland	Detroit
Prepaid hospitalization:						
Insurance company	61.1	31.2	40.3	35.9	16.3	34.3
Blue Cross	37.3	64.1	58.4	54.4	74.8	63.6
Employee benefit association	.9	.4		9.7		
Company plan	.7	4.2	.7		8.9	1.3
Labor union		.1	.6			.8
Prepaid surgical benefits:						
Insurance company	93.4	76.8	73.5	63.8	62.1	27.8
Blue Shield-Blue Cross	.6	13.7	15.5	27.3	15.9	69.9
Employee benefit association	3.1	.6	3.8	8.0	2.2	
Company plan	1.8	8.5	5.5	.9	19.8	1.4
Labor union	.8	.4	1.7			.9
Prepaid medical care:						
Insurance company	91.9	60.0	71.4	54.7	53.1	62.0
Blue Shield-Blue Cross			8.3	.1	1.7	7.7
Employee benefit association	.3		3.6	45.2	25.0	5.1
Company plan	5.3	38.9	13.4		19.8	10.9
Labor union		1.1	3.3		.4	14.3
Organized cash sickness:						
Insurance company	39.7	37.2	59.2	35.9	41.9	86.2
Company plan	48.3	32.3	34.9	39.2	26.0	11.1
Employee benefit association	11.9	29.9	5.5	24.9	31.5	1.9
Labor union	.1	.6	.4		.6	.8

Source: Research Council for Economic Security, 1948.

Mr. O'Connor. Speaking of private insurance companies only, and not including nonprofit plans, the volume of accident and sickness insurance has increased over the last 10 years from a figure of $240,000,000 in premiums to slightly over $1,000,000,000 in 1948. This plainly indicates the desire of the American people for voluntary protection and clearly shows that private companies are desirous of selling their protection to as large a number of American citizens as possible.

In referring to compulsory plans of insurance, I mention the Rhode Island monopolistic State sickness-compensation plan. Although it was the first to operate, it has been repudiated by the three States that have since enacted sickness-compensation plans. It is interesting to note this fact because in the present controversy concerning national health insurance we are being told by some proponents that Government monopoly is not only proper and American but also the most beneficent way to administer a program for the public good. It has not proven so in Rhode Island.

Both California and New Jersey, whose plans permit private insurance companies to compete with the State fund for the business, private companies are able to offer more to the worker at the same or less charge than the Rhode Island plan, which naturally repudiates as a fallacy that a Government monopoly system is superior. From the Rhode Island experience, is there any reason to believe that the pattern—taxes and service—would be different under a Government monopolistic medical-care program as called for in this bill? Would not the beneficiary be forced to accept whatever arrangements the Government agency dictates?

Senator DONNELL. May I ask Mr. O'Connor a question?

Senator MURRAY. Yes.

Senator DONNELL. He says that the Rhode Island plan was the first to operate and that—

> it has been repudiated by the three States that have since enacted sickness compensation plans.

Are the three States the ones you have just mentioned?

Mr. O'CONNOR. New Jersey, California, Rhode Island. Rhode Island's originally went into effect in September 1942 and it was monopolistic. Then California came along and then New Jersey; and now New York will have it in effect on January 1.

Senator MURRAY. The Rhode Island plan is still in operation?

Mr. O'CONNOR. Yes, sir.

Senator MURRAY. And, of course, the people of that State could reject it if they wished to and follow some other method of handling the plan?

Mr. O'CONNOR. It has been in effect since September 1942, and there is no objection by the public at all. I think there are $25,000,000 in the fund.

You see, Rhode Island, California, New Jersey, and Alabama were the four States that since the enactment of the Unemployment Insurance Act takes the worker as well as the employer. And when the war came along with the increased pay roll and with big wages, Rhode Island thought they had enough in the pot from the employer, so why not give the worker something for the taxes he was paying, so they amended the act and made it a State monopolistic plan. Then California followed later, then New Jersey, and now New York.

As a part of the record I desire to file Publication No. 72 entitled "Roads to Better Health" recently released by the Research Council for Economic Security. This publication sets forth the various plans and programs provided under our public health and welfare systems, the military medical services, those provided by private medicine, prepayment medical care, and industrial programs. This study very properly shows how extensive the coverage is and the number of people to whom it already applies.

Senator DONNELL. Mr. Chairman, I move that Publication No. 72 referred to be printed in full in the proceedings of this hearing.

Senator MURRAY. It may be done.

(Publication No. 72 is as follows:)

Roads to better health

[The following summary shows that many organizations, both public and private, are active today in promoting better health. They reach into every part of the country and offer a wide variety of services. The figures given in round numbers are the best available estimates. In a few cases there are duplications in coverage between items. Where no date is given, the figures are current.]

Plans and programs	Functions and services	Present coverage	Provided by—	Specific plans in operation
A. PUBLIC HEALTH				
1. Public health programs	Promote sanitation and hygiene; control communicable and preventable diseases; preventive medicine and health education.	1,791 counties; 99,401,690 population.	Federal, State, local governments.	U. S. Public Health Service; 48 State departments of public health; 20,554 voluntary health agencies (1943).
2. Public hospital	Hospitalization free to poor and at partial or whole expense to others.	817,000 beds	State, local governments	State hospitals, 648,386 beds (1948); county hospitals, 101,327 beds (1948); city-county hospitals, 84,956 beds (1948).
3. Sanitary and medical laboratory service.	Diagnosis of communicable and infectious diseases; examination of milk, water, and foods.	5,237 sanitariums (1946); 1,350 laboratory personnel (1946).	Public, private hospitals, laboratories.	U. S. National Institute of Health; sanitation, food and drug control, and laboratory services of U. S. Public Health Service; State departments of public health, hospitals, laboratories, and universities.
4. Public health nursing	Prevention and reduction of sickness in the population.	22,605 nurses (1948)	State, local governments; voluntary agencies.	Division of Nurse Education of U. S. Public Health Service; 1,393 voluntary agencies (1943); State and local departments of public health.
. School health service	Physical examinations and inspections; school sanitation and hygiene; health education.	30 States	Public, private school systems.	30 States with mandatory health examination, medical inspection (1946); 47 States with mandatory physical and health education (1946); State and local school systems.
B. PUBLIC WELFARE				
6. Maternal and child health care.	Prenatal care, children's clinics, and nursing service.	168,000 crippled children, 200,000 mothers, 500,000 children given health check-ups.	Federal, State, local governments; voluntary agencies.	United States social-security grants for maternal and child health services; State and loca units of maternal and child care; 195 voluntary agencies (1943).
7. Medical care for low-income classes.	Hospitalization, ambulatory, and institutional care; diagnostic and curative medical services and supplies.	5,000,000 persons	Federal, State, local governments; clinics, physicians, social agencies.	Public medical care in New York (585,896 cases in 1947); State, city, county hospitals; public dispensaries; departments of public welfare.
8. Nonprofit clinics	Clinics and health centers to provide medical care to ambulatory cases.	8,000 dispensaries	Public agencies, voluntary organizations.	236 dispensaries, 1,100,000 cases treated by New York State Department of Social Welfare; 8,000 dispensaries in the United States in 1930; dispensaries of hospitals, medical schools, governmental agencies.
C. MILITARY MEDICAL SERVICES				
9. U. S. Army Medical Department.	Hospitalization, medical treatment, nursing.	1,500,000 in military forces	U. S. Government	Medical personnel, 10,000 physicians, 1,740 dentists, 6,000 nurses, sanitary corps, administrative corps; 137 hospitals, 73,700 beds.
Bureau of Medicine and Surgery of the U. S. Navy Department.	Sanitary control and physical therapy; physical examination, diagnosis, and rehabilitation.			
10. United States veterans medical benefits.	Hospital and other medical care for service-connected illness; hospitalization to needy for non-service-connected illness.	549,300 hospital cases (1948); 6,000,000 medical treatments.	U. S. Veterans' Administration.	U. S. Veterans' Administration (3,536 physicians in 1948); out-patient treatment; dental activities (947 dentists in 1948); VA hospitals with 135,943 beds, 11,065 nurses.

Roads to better health—Continued

Plans and programs	Functions and services	Present coverage	Provided by—	Specific plans in operation
D. PRIVATE MEDICINE				
11. Private medical practice	Medical examination and diagnosis, medical treatment, prevention, and research.	120,000,000 by medical care under private contract.	Individual medical practitioners, group clinics.	Fee for service system; medical prepayment plans; 170,000 physicians, 45,000 specialists, 435,000 nurses (1948), 83,000 dentists (1948).
12. Private medical facilities	Hospitalization, laboratory examinations and analyses, specialized treatment.	395,000 hospital beds, 11,600,000 hospital admissions.	Individuals, private corporations, foundations, religious and philanthropic groups.	Church hospitals, 144,036 beds (1948); nonprofit hospitals, 208,936 beds (1948); proprietary hospitals, 50,781 beds (1948).
13. Group medical practice	Medical diagnosis and treatment, surgery, specialties.	407 groups (1946); 3,275 physicians (1946).	Individuals, organizations, corporations.	Private groups, 319 (1946); sponsoring organizations, 31 (1946); corporate groups, 12 (1946)
E. PREPAYMENT MEDICAL CARE				
14. Prepaid hospitalization	Services and indemnities for hospital care.	56,000,000 persons	Insurance, employers, nonprofit organizations.	Insurance companies, 23,000,000; Blue Cross plans, 32,000,000; medical society plans, 2,000,000.
15. Prepaid surgical benefits	Surgical benefits and indemnities	28,000,000 persons	Insurance, industrial welfare plans, nonprofit organizations.	Insurance companies, 17,000,000; Blue Shield, Blue Cross, 11,000,000; medical society plans, 1,000,000.
16. Prepaid medical benefits	Medical care and indemnities beyond hospitalization and surgery.	13,000,000 persons	Insurance, medical societies, nonprofit organizations.	Insurance companies, 3,000,000; Blue Shield, Blue Cross, 5,000,000; medical society plans, 4,000,000.
F. INDUSTRIAL PROGRAMS				
17. Medical benefits under workmen's compensation.	Medical services provided for recovery and rehabilitation of the worker.	30,000,000 workers	State, employers, and insurance companies.	Unlimited medical aid 26 States; limited medical aid 22 States.
18. Industrial health programs.	Provide industrial nursing, medical services, examinations, plant sanitation and hygiene.	18,000 plants; 2,000,000 workers.	Factories and business establishments.	Division of Industrial Hygiene of U. S. Public Health Service; 8,000 industrial hygiene units in 47 States; industrial safety service in 18,000 plants; National Safety Council, 8,000 members.
19. Vocational rehabilitation	Educational, medical, and other services to remove or minimize disabling conditions.	200,000 cases	Federal and State Governments.	48 State boards of vocational education; 31 State agencies for blind; U. S. Office of Vocational Rehabilitation; U. S. Veterans' Administration.
20. Industrial prepayment medical care plans.	Protect workers against costs of illness and accident.	1,800,000 persons	Employers and employee benefit plans.	Health department of Tennessee Coal, Iron & Railroad Co., 129,000; workers medical and relief department, Endicott Johnson Corp., 50,000.

Mr. O'Connor. It may be true that the existing system is not perfect, but certainly the best way is to make additions and strengthen the weak spots rather than sweep it aside and install a completely new program. As I said before, no one will doubt the need for better health protection, but there is real doubt that the forces that would be set in motion under a Government compulsory sickness program would stop with the realization of such a system.

Today we have both public and private agencies performing services properly within their scope; many different agencies are operating and developing competition between them and bringing out the best for our people; there is a great amount of constructive and preventive health work being carried on. Wherever the police power is required, and no private aid forthcoming, the Government can very properly take care of such situations, but where no crisis exists voluntary methods should remain undisturbed and permitted to meet the needs. The variety of medical services set forth in Roads to Better Health allows for such flexibility.

Our system of dispensing medical care has come a long way in the last 10 years. It is still and will always continue to be in the process of evolution striving to improve the health of our people. If the medical profession and the large number and variety of our present agencies are allowed to grow, they will develop new functional systems which will be much better and will meet the needs more thoroughly than is proposed under this bill. Blue Shield is now developing medical-care plans in the various States in competition with private insurance, and through these two mediums the public is receiving the best obtainable service at low cost.

Insurance companies in this country are old, well-established institutions. They do not wish preferential treatment, but they certainly do not wish to be excluded; and if this bill was enacted it would. to a large extent, destroy a volume of business now written in the hospitalization and medical-care fields. Furthermore, I believe this bill would be a springboard to further legislation—perhaps the adoption of the payment of sickness compensation—which would certainly wipe out a volume of group accident and sickness insurance that now exceeds $400,000,000 in premiums, and which pays back 70 to 85 cents on the premium dollar.

Senator Murray. The policies that are issued by these private organizations do not cover the entire field of medical care and hospitalization and everything that is necessary to take care of health?

Mr. O'Connor. They would not go as far as the bill would go. That is true.

Senator Murray. They would not go as far as the bill goes?

Mr. O'Connor. No.

Senator Murray. The American Medical Association has made statements that a very large percentage of the American people are unable to meet the cost of medical care. They say that a man having an income of less than $3,000 a year would be unable to meet such costs from an income of such size.

Mr. O'Connor. Did they not quote that figure some years ago?

Senator Murray. Yes.

Mr. O'Connor. And now they are trying to refute it; have they not attempted to?

Senator MURRAY. No; I do not understand so. I understand that statement about the $3,000 a year was given some years ago, and now if applied to the present situation it would be higher.

Mr. O'CONNOR. About $5,000.

Senator MURRAY. About $5,000 a year. An American with an income of $5,000 a year would be unable to meet the cost of a major illness.

I have received letters, and I am sorry I do not have them here with me, I did not bring them along, but I get these letters almost every day from all parts of the United States. I got a letter from California telling me of a situation down there where a family met with illness and it cost them $5,000. It practically broke the family, and they are now on relief.

So, it does seem to me it would be impossible for your private system to furnish adequate security for the people of this country—the people who need it most.

Mr. O'CONNOR. Of course, under insurance, you never attempt to cover fully the entire risk. Usually, as you have on your fire policy, you are a coinsurer with the insurance company, and insurance can only cover so far; but you cannot cover the entire risk—and it is not intended to.

Senator MURRAY. It seems to me if it does not cover the entire field it is inadequate. For instance, I do not want to be carrying half a dozen policies in my pocket. I cannot keep track of them all.

I would like to have a system so that when I pay my money I know I am going to get full and adequate protection, and it seems to me that a policy which gives me only limited protection is inadequate. And when I come to suffer a severe illness, I come to look at my policy—and I am not going to get anything on it.

Mr. O'CONNOR. As you know, medical care was about the only coverage that was originally missing from accident and sickness policies. They take loss of time and take hospitalization and in the surgical field. Medical care is a new coverage in the insurance companies, and it has been probably brought about by this bill of yours—no doubt about it, because the companies have gotten interested in it in the last 5 years.

Senator MURRAY. You have increased your premium?

Mr. O'CONNOR. That is going up all the time.

Senator MURRAY. You are charging more for the services you give them than before?

Mr. O'CONNOR. That has to be taken in the premium. Now, Senator, bear in mind that today we talk about covering the people. There are slightly over $400,000,000 in premiums today on what we call group accident and sickness insurance. That has been answering a very vital problem, and there is a tremendous increase in it.

Senator MURRAY. Those policies are usually taken by the corporation?

Mr. O'CONNOR. That is right. The contact is made with the employer, and the employer usually pays 50 percent of the premium.

Senator MURRAY. And, when they lose their employment, what happens?

Mr. O'CONNOR. When they are discharged or transferred to another firm?

Senator MURRAY. When discharged or laid off.

Mr. O'CONNOR. The coverage expires at the end of 30 days.

Senator MURRAY. In various parts of the country now, there are thousands of people being laid off in industry. For instance, there have been shut-downs in Butte, Mont., where I live; corporations there have shut down their mines and discontinued some of their big development programs. Now, when those people lose their jobs, they also have to lose their insurance.

Mr. O'CONNOR. It ceases in 30 days thereafter.

Senator MURRAY. It ceases in 30 days?

Mr. O'CONNOR. That is right.

Senator MURRAY. And thereafter the group policy is no longer a security for them.

Mr. O'CONNOR. That is right.

Senator MURRAY. Proceed with your statement.

Mr. O'CONNOR. We live in an age of propaganda by slogans, when debatable programs are sold by the use of catchwords that have little to do with reality. If a Government compulsory medical-care program is good for America, we want it. If it would not be good, we do not want it. It is time, therefore, to be realistic and get down to facts.

Will anyone dispute the fact that the United States is among the most healthful nations of the world, perhaps the most healthful of the large nations? With 6 percent of the world's population, we have more hospital facilities than the rest of the nations put together. Although it is stated that 68,000,000 Americans cannot afford to pay their medical bills, it is a recognized fact that practically anyone who can meet his other bills can meet his medical bills as well—either directly or through insurance.

> The issue is not whether we can afford medical care—

says a report of the Brookings Institution—

> but whether we should be compelled by law to give payment for medical care a top priority.

I believe we will agree that there is a small proportion of people who cannot afford to pay their medical bills or insurance premiums. These people in many instances cannot pay for other necessities; therefore they should be provided by Government; but the fact that needy persons cannot pay for medical care does not call for the infliction of a Government compulsory program on the rest of the population.

The issue of compulsory health insurance in the United States has been made and is now a matter of partisan politics and ideology. If adopted, that same partisanship and ideological thinking would pervade and control the management of such a system. In England some of the terms and characteristics of the management of the British health service system have been determined by the personal characteristics and the political philosophy of the present Minister of Health.

Many estimates have been made of the cost of this proposed system, ranging from $5,000,000,000 to $15,000,000,000, but what the actual cost would be depends entirely upon what the Federal Government wants it to be; and if we run true to form, it is a certainty that the cost will run much higher than under our present system, with no assurance that the quality of care will be any better or will improve the health of the Nation. It is a fact that compulsory health insurance has never improved the health of the people in any country where it has been tried; instead, it has become a political football making for higher costs and eventually affecting the entire economy. Is there any reason to believe it would be any different here than abroad?

Senator MURRAY. Before you go any further, Mr. O'Connor, you say:

> It is a fact that compulsory health insurance has never improved the health of the people in any country where it has been tried; instead, it has become a political football making for higher costs and eventually affecting the entire economy.

Now, where did you get the basis for that statement?

Mr. O'CONNOR. The idea is you start off in a small way and then expand. Great Britain is an example in point.

Senator MURRAY. Are you familiar with the situation in Great Britain?

Mr. O'CONNOR. To a certain extent, yes, sir.

Senator MURRAY. Have you been over there?

Mr. O'CONNOR. No, sir.

Senator MURRAY. Then where do you get your familiarity and your information with respect to Great Britain?

Mr. O'CONNOR. From studies that have been made of their system.

Senator MURRAY. I have myself read a lot of articles published in this country, but they are not regarded as being reliable by some people. We have had information direct from England, and it is to the effect that they are surprised at some of the conclusions the people of this country have drawn with reference to their system.

As a matter of fact, they are entirely satisfied with it. In fact, it has been so satisfactory there that now the Conservative Party over there is beginning to claim they are the ones that instituted it.

Mr. O'CONNOR. I would hesitate to discuss it.

Senator MURRAY. They want to take credit for having instituted such an admirable program.

Mr. O'CONNOR. I would hesitate, Senator, to even discuss the British program, after not quite 1 year's experience.

Senator MURRAY. I see.

Mr. O'CONNOR. What I meant by the statement was that the British system when it began was a small system, and since last July it has expanded and has been expanding right along.

Senator MURRAY. It is a different system from ours—or would you want to discuss that?

Mr. O'CONNOR. I would not want to discuss the British system.

Senator MURRAY. You are not actually familiar with all the details. All you know is what you have read in the press. Is that right?

Mr. O'CONNOR. And even so, I would not want to criticize it on the basis of 1 year's experience, because it is not enough. It would not be right in such matters to take 1 year's experience to judge such a serious system.

Senator MURRAY. You will pardon the interruption.

Mr. O'CONNOR. In a study recently released by the Institute of Life Insurance on the social-security program of New Zealand, referring specifically to the health program, it said:

> Compulsory health insurance has been in effect in New Zealand for a decade and its cost has jumped every year. In the 1948–49 fiscal year outlays for the medical plan are officially estimated at a new high of over 7½ million pounds,

an increase of close to 50 percent in the last 5 years and equivalent to more than a third of the costs of all social services before the war.

Before serious consideration is given to a national compulsory health program we should ask: "Will our economy stand the cost of such a program?" We must realize that additional taxes, added to the tremendous tax load now being carried by the American people, could easily break the back of our economy, and cause this Nation to fail just as other nations have cracked because the tax load became so heavy the people could not carry it.

Wide regional differences in population, climate, economic conditions, social problems, and other factors make the health problem complex and far-reaching. It is argued that more physicians are needed, especially in the rural areas, but this is an incomplete answer. In 1940, the death rate of the United States was about 9 percent higher than Canada's (in the comparable Canadian census year, 1941) although we had about 30 percent more physicians per capita.

Poverty is an entering wedge for illness, but kidney trouble strikes the poor less often than it does the rich. The southern States are beset by much illness, yet cancer is less common there. There is more to the health problem than the supply of medical care. While health is a national problem in the sense that all people are affected by it in one way or another, it is really a combinattion of layers of regional, local, and individual problems sandwiched together. No matter which of these conditions we undertake to improve, we would waste part of our effort if we blanketed the country with a packaged program.

If the proportion of physicians and hospitals beds is two and three times as large in some States as in others, this does not mean that the remedy consists in providing two or three times the number of physicians and hospital beds in underprivileged areas. The medical needs are not necessarily for mere multiplication of numbers. Even more important may be the intensification or reorganization of special services and the more strategic placement of facilities adapted to the specific needs of each section.

Those who advocate some single measure to safeguard national health fail to recognize the complexity of the problem.

The health of our people can be safeguarded not so much by meeting problems of immediate disease but rather by improving all the conditions of life which affect health. We can secure gains in national health in the long run only about as rapidly as we can improve the living standards, the educational advantages, and the economic opportunities of our people.

In closing I desire to again repeat the suggestion that the most realistic approach to the problem of improving the health our people is to create an impartial commission to thoroughly explore the entire situation. There are entirely too few facts available for anyone to form a fixed opinion. There have been too many wild and slanted opinions expressed on this issue. Let us once and for all time get a factual report of the situation and then have the American people decide the issue.

Senator MURRAY. Any questions?

Senator DONNELL. No questions, Mr. Chairman, but at this point I would like to let the record set forth in full an article dated March 15, 1949, appearing in a publication by the National Economic Council, Inc., Empire State Building, New York 1, N, Y., entitled "Cecil

Palmer's Commentary—II. The British Experiment in Socialized Medicine."

Senator MURRAY. That may be inserted in the record, and I would like permission to also present a statement in that connection.

Senator DONNELL. Certainly.

Senator MURRAY. You do not wish to ask questions?

Senator DONNELL. No questions.

Senator MURRAY. I just want to ask you, Mr. O'Connor, if you did not think that the present unemployment condition that is developing in this country, if continued, would or would not have a very serious effect upon your conclusions which you have presented here today.

Mr. O'CONNOR. It may have a temporary effect; yes, sir.

Senator MURRAY. I noticed an editorial in the Washington Post of June 16 in which, among other things, it said, and I quote from it:

> Today's widespread economic anxiety has been heightened by memories of the early 1930's and by the living upsets of two World Wars. It has been intensified by inflation, which has wiped out savings. But its chief abettor through the years has been a developing factory civilization.
>
> Only about one-fourth of the population now lives on farms. While many farmers, especially of the tenant class, feel as insecure as their city cousins, yet generally they have more confidence about their food and shelter. * * *
>
> No doubt most Americans and all other people need more sense of inner psychological security developed in them. But those who deplore this interest in a "safe" economic tomorrow and who themselves have generally had their own security buttressed by inherited wealth, might lose some of their unconcern about how their bills were to be paid if they tried getting along on the $500 to $1,999 a year received by about 30 percent of nonfarm wage earners.

Do you think that that is a wise observation on the part of that editorial writer of the Washington Post?

Mr. O'CONNOR. It might be; you might consider it so. But I do not think, Senator—in fact, I hope, in answer to your previous question, that it does not come about that we will have a recession. I hope we do not have one.

Senator MURRAY. But if the unemployment condition continues or gets worse, it will have a very serious effect upon millions of American citizens?

Mr. O'CONNOR. Very much; very bad effect.

Senator MURRAY. With reference to taking care of their health as well.

Mr. O'CONNOR. That is right, sir, taking care of their health—and all other things.

Senator MURRAY. And would it not have a tremendous effect upon your policy holders, in fact? No doubt it would cause many of those in this group insurance you have been talking about to be without jobs and, therefore, without the security of such group insurance.

Mr. O'CONNOR. And many other things; yes.

Senator DONNELL. Mr. Chairman, I request that the article I referred to just a moment ago be inserted at the conclusion of the testimony of this witness.

Senator MURRAY. Yes; that will be done.

Thank you very much, Mr. O'Connor.

(The article referred to is as follows:)

[From Economic Council Papers, March 15, 1949]

CECIL PALMER'S COMMENTARY—II. THE BRITISH EXPERIMENT IN SOCIALIZED MEDICINE

(During the months Mr. Cecil Palmer, widely known British author and publisher, is in the United States as the guest of the National Economic Council, he will write semimonthly comments on conditions in Briton. A copy of each comment will go to NEC subscribers.)

When the British socialist government inaugurated its state medical service on July 1, 1948, it told the people that this "medicine for all" would be "free."

It is, of course, nothing of the sort. Indeed, in the first 8 months of its practical operation the cost has exceeded the original estimate by more than $234,000,000. To be sure, a great deal can be had for the asking—in theory, at least. This gives the illusion, to those who do not take the trouble to wonder where all the money is coming from, that the service is free.

The list of what can be obtained for the asking—if it is in stock—is an imposing one. Not only does it cover the services of medical doctors and dentists, but it includes as well hospital treatment, maternity and child welfare, home nursing, spectacles, dentures, deaf aids, and artificial legs, as well as drugs and medicines.

Perhaps its most alluring feature is reserved for those who are bald. For men, there are wigs; for women, transformations. And because nobody needs to pay a nickel when he receives these things, they are all free.

The whole scheme is a swindle because it pretends to offer something for next to nothing and actually gives next to nothing for something.

The Government has not delivered the goods. There are not enough doctors. There are not enough nurses. There are not enough hospitals. There are not enough dentures. There are not enough clinics and there are not enough wigs.

The scheme is a fraud because it has been foisted on the public as a free medical service. The dishonesty of this claim is revealed by the fact that contributions by patients to the health service alone are $2,800,000 a week. If that is a free service, it would be nice to have an estimate of one that isn't. And the costs above the amounts paid in for so-called health insurance will have to be paid for by taxes collected from the very same people. Many of these taxes will be hidden, so as to maintain a governmentally created illusion of free service.

Britain's adventure into socialized medicine has already done two things. I shall leave it to my American friends to decide whether they are good.

One, it has changed the status of the doctor.

The physician's livelihood, his professional advancement, his first loyalties, all have been commandeered by a new master—the state, which pays him with the citizens' money.

Two, it has destroyed the relationship between doctor and patient.

Despite the solemn assurances of Mr. Aneurin Bevan, Minister of Health, privacy as between physician and patient is gone. In a leaflet, explaining the new services, and issued to all householders by the Ministry of Health, this assurance is given: "Your dealings with your doctor will remain as they are now, personal and confidential." Let us see whether the assurance is true.

Statutory Instruments 506 and 507 of 1948, create an entirely new situation. Under the heading "Terms of service," S. I. 506 requires the practitioner "to keep records of the illnesses of his public patients and of his treatment of them, in such form as the Minister may from time to time determine, and to forward such records to the local executive council." This executive council consists largely of lay persons. The person who can read your whole medical history may be your next-door neighbor—or his wife.

Small wonder, then, that thousands of doctors—and tens of thousands of lay people, too—are in revolt. Not only do the doctors feel that the State is thus making them break their Hippocratic oath of confidence between them and their patients, but they are vastly overworked and underpaid.

Under the scheme each practitioner in large areas is allotted 4,000 patients. In small areas the number may run as low as 2,500. How can one man treat so many people with professional skill, particularly when so many of those who visit his surgery are suffering from trifling complaints, and no small number are downright malingerers?

For all this added work and responsibility the doctor receives $3.20 per year per person from the state—out of which must come burdensome income taxes and heavy overhead.

The totalitarian nature of the scheme is becoming more and more clear. In theory a patient can remain outside the scheme. As it works out, if he does so, he must pay twice for his medical service: Once to the state and a second time to the doctor of his choice.

(Subsequently Senator Murray submitted the following correspondence for inclusion in the record:)

July 5, 1949.

Mr. Edward H. O'Connor,
Managing Director, Insurance Economics Society of America,
Chicago, Ill.

Dear Mr. O'Connor: When testifying before our Subcommittee on Health on June 29, 1949, you said at one point:

"Speaking of private insurance companies only, and not including nonprofit plans, the volume of accident and sickness insurance has increased over the last 10 years from a figure of $240,000,000 in premiums to slightly over $1,000,000,000 in 1948 * * *."

And, at another point, you referred to: "* * * a volume of group accident and sickness insurance that now exceeds $400,000,000 in premiums, and which pays back 70 to 85 cents on the premium dollar."

I do not have authoritative figures for 1948, but I do have such figures for 1947 and prior years. Is it not a fact that in 1947, for example, total health and accident insurance business in the United States received premiums of about $823,000,000? That, of this amount, about $518,000,000 was paid in for individual policies, and that about $305,000,000 was paid in for group policies? Is it not also a fact that the companies doing this business paid out to policyholders, altogether, an amount less than 53 percent of premiums paid in? That the individual policy business paid out an amount less than 42 percent? That the group policy business paid out an amount less than 72 percent?

For your information in answering these questions, I would add that my figures are based on the Spectator Pocket Register of Accident Insurance, 1948; that when referring to payments to policyholders I am using their figures on "losses incurred, including adjustment expenses"; and that I refer to payments as "less than" the indicated percentages because those percentages include "adjustment expenses" which, I understand, are not payments to policyholders.

Thanking you for your replies to my questions.

Sincerely yours,

James E. Murray.

Insurance Economics Society of America,
Chicago, Ill., July 12, 1949.

Senator James E. Murray,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Public Welfare,
Washington 25, D. C.

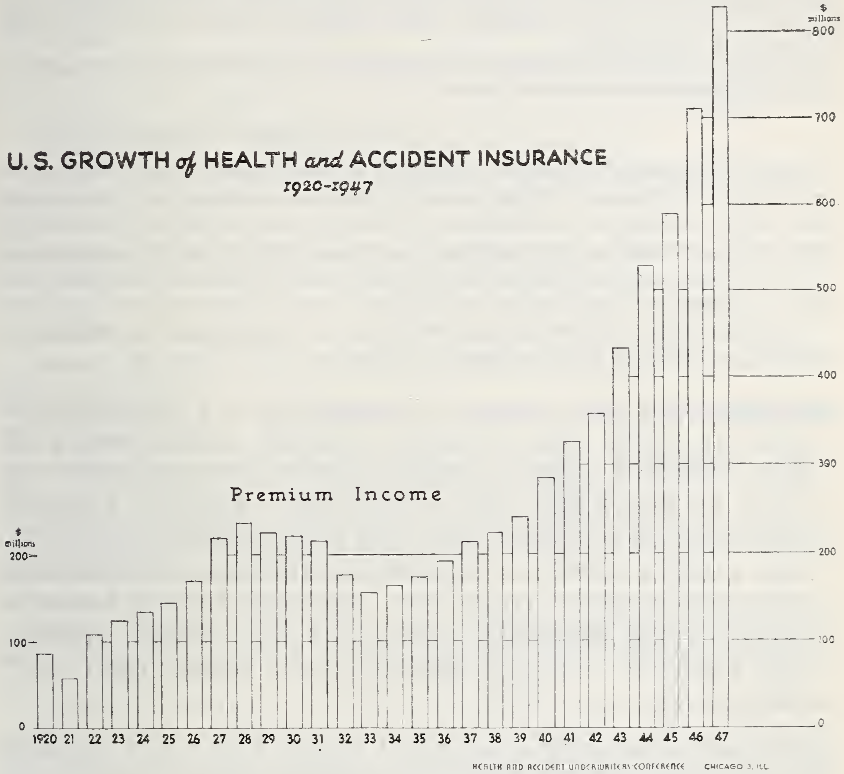
Dear Senator Murray: I am in receipt of your letter of July 5 and pleased to note your interest in obtaining confirmation of some of the data contained in my testimony, which I had the privilege of placing before your committee in my personal appearance on June 29 last.

My figures on the total premium income of private insurance companies, exclusive of nonprofit plans, are taken from the 1949 edition of the Argus Casualty and Surety chart covering experience to December 31, 1948. Actually the chart indicates a total of accident and health premiums of $1,033,000,000 which we have discounted to $1,010,000,000 because some slight amount of industrial life-insurance premiums apparently have been included in these accident and health figures.

A chart showing the growth of accident and health insurance from 1920 through 1947 is enclosed as well as a list of accident and health premiums for the years 1919 through 1948.

I believe these figures will justify my statement.

In a survey of total premiums for the year 1948—group accident and health—just released by the Life Insurance Association of America covering 215 companies it shows a figure of $385,600,000. Since this survey does not include all the companies writing in the field it may be rightfully assumed there is at least $15,000,000 additional in force making the figure of $400,000,000 in total group accident and health premiums.



Accident and health net premiums, 1919–48

	Premium		*Premium*
1919	$69, 034, 591	1934	$164, 653, 985
1920	85, 055, 091	1935	174, 601, 515
1921	58, 337, 810	1936	191, 951, 614
1922	108, 194, 937	1937	214, 024, 075
1923	124, 311, 003	1938	223, 115, 712
1924	133, 641, 162	1939	241, 415, 688
1925	143, 848, 371	1940	286, 091, 231
1926	169, 449, 286	1941	326, 768, 706
1927	217, 938, 051	1942	358, 927, 896
1928	233, 405, 207	1943	433, 343, 999
1929	222, 591, 643	1944	518, 238, 592
1930	220, 567, 294	1945	583, 241, 839
1931	216, 112, 798	1946	701, 351, 338
1932	177, 074, 505	1947	825, 239, 820
1933	157, 564, 949	1948	1, 010, 000, 000

You are absolutely correct in your statement regarding the figures on group insurance contained in the Spectator Pocket Register of accident insurance. The amount returned to policyholders is as you state less than 53 percent over-all—42 percent on individual and 72 percent on group. However, if you will run through the Spectator you will find that a number of companies have group loss ratios of over 75 percent in some instances, and in others even over 85 percent which is natural due to the many variations of coverage in the contracts issued.

It is perhaps needless for me to tell you that in the group-insurance field the coverages are not of one type but are designed to meet certain contingencies involved in the class of work being performed, the working conditions, wage level, standard of living in the area and the peculiarties of the industry, consequently the loss ratios are bound to vary according to the extent of coverage, the premium charged, etc.

Thanking you for your interest in this subject and assuring you of my cooperation at all times in this problem, I am

Sincerely,

E. H. O'Connor, *Managing Director.*

Senator Murray. Now we will hear the witnesses from the Senate and from the House. We are very glad to welcome you gentlemen here today. I have not had time to study your bills very carefully, but I am sure that as the result of your presentation here this morning we will get a pretty good understanding of the bill and its purposes and the program intended by the bill.

The first witness this morning will be our distinguished colleague, the Senator from Vermont, Mr. Flanders.

STATEMENT OF HON. RALPH E. FLANDERS, A UNITED STATES SENATOR FROM THE STATE OF VERMONT, ACCOMPANIED BY HON. IRVING M. IVES, A UNITED STATES SENATOR FROM THE STATE OF NEW YORK; HON. CHRISTIAN A. HERTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS; HON. JACOB K. JAVITS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK; HON. CLIFFORD P. CASE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY; AND WINSLOW CARLTON, MEDICAL CARE CONSULTANT, NEW YORK, N. Y.

Senator Flanders. Mr. Chairman, I wonder if the others associated with me on this bill might all sit at this table here with me at this time.

Senator Murray. Yes.

Senator Flanders. There is Congressman Herter, Congressman Javits, Congressman Case, and Mr. Winslow Carlton. Also associated with us is Senator Ives, who is sitting with us but not at this table.

Senator Murray. I certainly welcome this array of Republicans appearing here this morning. I remember back in 1939 when the distinguished former Senator from New York, Senator Wagner, was a member of this committee and we introduced the first bill calling for a voluntary insurance program, we had no sympathy whatever from the Republican side.

Now, I understand, they have come to understand, they have come to recognize that ours is a real problem, and it is a very real problem for the American people. So, I am very happy to have today these very distinguished Members of the House of Representatives here, to help us in our effort to solve this problem.

Senator Ives. Further than that, Mr. Chairman, if I may interpose an observation, we Republicans think we have a very substantial contribution to offer in the proposal we are making.

Senator Murray. I am sure you think so. [Laughter.]

Senator **Donnell**. Senator, I gather from the remark you have made that your contribution differs in some respects from the administration bill.

Senator **Ives**. Yes.

Senator **Murray**. And that is what we want to see, where it differs and whether it is an improvement. You may proceed, Senator Flanders.

Senator **Flanders**. Mr. Chairman and members of the committee, I am here with respect to S. 1970, which is the so-called National Health Act.

Senator **Murray**. You have a prepared statement?

Senator **Flanders**. I have a prepared statement, yes, sir. It will take about 15 minutes to read it, I should judge.

Senator **Murray**. Our rules and regulations here provide you should have submitted that statement to the committee in advance, otherwise you must be excluded from testifying. [Laughter.]

Senator **Flanders**. I am sorry. Mr. Chairman, I wish I could have done that but it was only finished this morning.

Senator **Murray**. Of course, I am being a little facetious. I know you are pressed.

Senator **Ives**. Yes, Mr. Chairman, like some other folks, we operate under pressure, too.

Senator **Murray**. I realize the pressure you have been under. I will be very glad to have you proceed, Senator Flanders.

Senator **Flanders**. Thank you. Congressman Herter has told me he will have to leave in a few minutes, so I would like to allow him to break in, if I have not finished by then.

Senator **Murray**. Yes.

Senator **Flanders**. Mr. Chairman, in supporting the national health bill I wish first to make a general statement with regard to the social service bills and to the balancing of the budget.

There are three lines of social service which are matters of Federal concern. They are housing, health, and education. That minimum standards should be available in these three fields is a governmental responsibility. Where these responsibilities cannot be met by local action, the interest of the Federal Government is so great as to warrant its active participation.

In my mind the Government has no business to move in the direction of equality of income for its citizens or equality of wealth. It does have a responsibility for equality of opportunity so that each boy and girl may make of himself all that his inheritance in body, mind, and spirit permits. This responsibility it is which lies behind the Federal participation in these three areas.

We have the budgetary situation to consider. I believe that the Politburo is driving us too far in the direction of trying to fight psychological warfare on their part by the expenditure of billions for soldiers and armament on our part. By spending a few millions more for psychological warfare, of which the Voice of America is practically our only undertaking to date, we can decrease our military expenditures by billions and foil thereby the quite definite plans for economic ruin which have been planned for us by our Russian friends. If we are successful in this we can afford to expand safely and wisely our social program.

Mr. Chairman, I hope you will excuse me for getting into that subject. I intend to get into that subject at every opportunity.

Senator MURRAY. That is all right.

Senator FLANDERS. I believe in moving modestly at the present time into these three areas. I was one of those who cut down the size of the administration's housing bill. I regretted that the education bill did not for the present stop short at the primary-school system. In the case of this national health bill, my support does not envision going into it full scale and immediately. I believe it should be approached modestly and experimentally, developing the procedures as we go by following the pattern which is set forth in S. 1970.

This national health bill has a twofold objective:

(1) To make is possible, through voluntary prepayment plans, for everybody in the United States, of whatever income, to obtain adequate health care to the fullest extent that medical resources permit.

(2) To see that the quantity of health service is expanded and its quality raised throughout the Nation, by progressively eliminating shortages in our medical resources.

Basic in the bill's program are voluntary prepayment plans. Their subscription charges would be scaled to their subscribers' incomes, rather than flat-rate premiums. Mixed Federal-State funds would make up any difference between the aggregate of subscribers' payments and the cost of furnishing health-service benefits.

The bill also provides (*a*) special Federal help in areas where the shortage of health resources is particularly acute, in order to attract personnel and maintain modern facilities; (*b*) increased Federal aid to communities throughout the country for building hospitals and health centers; (*c*) Federal grants to medical and nursing schools; and (*d*) additional Federal aid to States for expanding their local public-health services.

Finally, the bill sets up machinery for constantly appraising the health needs of the Nation and for developing a national health program which would be periodically revised to keep pace with the growth in medical resources.

Mr. HERTER. If I may, Mr. Chairman, I might at this point put into a record a fairly detailed statement of the purposes and provisions of the bill which is in lay language rather than the technical language of the bill itself. I offer it because I think it might possibly be helpful to the committee if it were inserted at this point.

Senator MURRAY. If you would like for it to appear at this point, it may be so incorporated.

(Statement referred to is as follows:)

THE NATIONAL HEALTH ACT—RÉSUMÉ AND EXPLANATION

This national health bill has a threefold objective:

(1) To make it possible, through voluntary prepayment plans, for everybody in the United States, of whatever income, to obtain adequate health care to the fullest extent that medical resources permit.

(2) To see that the quantity of health service is expanded and its quality raised throughout the Nation, by progressively eliminating shortages in our medical resources.

(3) To do these things in such a way as to foster constructive freedom of action, and the responsibility that goes with it, on the part of both patients and doctors, individuals and associations, communities and States.

MAIN PROVISIONS

Basic in the bill's program will be voluntary prepayment plans. Their subscription charges would be scaled to their subscribers' incomes, rather than flat-rate premiums. Mixed Federal-State funds would make up any difference between the aggregate of subscribers' payments and the cost of furnishing health service benefits.

The bill would also provide: (*a*) special Federal help in areas where the shortage of health resources is particularly acute, to attract personnel and maintain modern facilities; (*b*) increased Federal aid to communities throughout the country for building hospitals and health centers; (*c*) Federal grants to medical and nursing schools; and (*d*) additional Federal aid to the States for expanding their local public-health services.

Finally, the bill sets up machinery for constantly appraising the health needs of the Nation and for developing a national health program which would be periodically revised to keep pace with the growth in medical resources.

BASIC PRINCIPLES

This bill does not bring about socialized medicine; on the contrary, it very greatly encourages the development of private efforts, which actually pace the program.

It invokes no means test; on the contrary it offers to everybody, poor or well-to-do, the right to obtain the same services as everyone else, at a cost scaled to his means.

The bill reflects the belief of its sponsors that great social needs can be met without falling into the errors of state socialism, and that needed services can be given at needed cost to our people without disrupting—but on the contrary, encouraging—the development of private initiative and enterprise.

The sponsors do not consider this bill necessarily the answer for all time to the health problem. For this reason they have provided the means for constant readjustment of the program on a rational basis. But they do consider the bill realistically designed to bring within everybody's reach all the care that the Nation's medical facilities can provide—and to assure the rapid development of enough facilities to include everybody, in every income group, who wants to use them. It thus places itself squarely in the American tradition of more and better services in response to voluntary demand.

HOW IT WORKS

The key to the program is the local, voluntary prepayment health-service plan. Many such plans already exist—Blue Cross, Blue Shield, innumerable group-health plans, industry plans, labor union plans, welfare funds, cooperatives, and so forth. Over 35,000,000 people are already enrolled in these plans.

The chief advantages of all such plans are (1) that by spreading the risks among a large number of persons they enable their subscribers to protect themselves, at a moderate cost, against ruinous personal losses, and (2) being organized and operated privately, without governmental management, they can reflect accurately the desires and needs of their members. Their chief disadvantage is that the flat-rate premiums which most of the plans must now carry are beyond the means of millions of otherwise self-supporting people. This is especially the case when doctors' services in the home and office and preventive medical care, as well as hospital services, are included. Premiums for such coverage may run from $100 to $150 per family, far too much for incomes in the lower brackets. As a result, only a few of the voluntary plans at present cover more than hospitalization and surgical care, a fragment of the health services people need.

This legislation contemplates hundreds of such nonprofit voluntary plans, each locally organized and operated. It will use existing plans, enabe them to expand, and open the way for new plans throughout the country.

Fundamental to the program is the requirement that these voluntary plans base the rate of payment by subscribers upon a percentage of the subscriber's income (up to $5,000). This provision will necessitate changing the method of charging practiced by most plans at present in existence. It is, however, essential for the purpose of opening voluntary plans to everyone by bringing in public aid for people of limited income without a means test.

In order to participate in the program, a State would set up a State health council. This council would divide the State into several regions, many of which have already been set up under the Federal Hospital Construction Act. Each region would be managed by a health region authority, made up of local people. On this authority and on the State health council there would be no practicing doctors, dentists, or others who provide health services since they represent groups with a direct financial interest in the public's contributions, but each authority and council would have medical and other advisory committees.

The bill sets up a national yardstick in the form of a comprehensive range of benefits, which it defines in detail and which includes the most vital health services. It further states that the subscription charge for this particular coverage cannot be less than 3 percent of the subscriber's income up to $5,000. The first duty of each health region authority is to estimate the normal cost in that region of supplying the national yardstick coverage.

Any plan operating in that region which provides the yardstick range of benefits will receive from the State (with Federal participation) the difference between its subscribers' payments and the estimated normal cost of the coverage.

A plan may offer a coverage less comprehensive than the national yardstick coverage, in which case it would charge proportionately less to its subscribers and any public contibution would be based on a proportionately lower allowed cost. Or a plan may provide a still more comprehensive coverage, in which case it must charge proportionately more and would have a proportionately higher allowed cost.

The maximum coverage a plan may offer under the bill's program will be fixed by the State health council. This maximum will be based on how much medical service can be provided in each of the State's regions by existing or reasonably obtainable personnel and facilities. The State may amend the maximum each year in the light of experience and in line with the growth of its medical resources.

HOW IT APPLIES

Let us suppose that a plan provides the yardstick coverage, for which it charges 3 percent of each subscriber's income. This would cover the subscriber and any dependents.

A subscriber with an income of $1,500 would pay $3.75 a month; one with $2,500 would pay $6.25 a month; and one with $3,800 would pay $9.50 a month. They would all get the same services, the deficit created by the lower incomes being made up by the State-Federal aid. Thus, if the annual cost allowed to the plan by the regional authority were $114 per family (which would be about the estimated average for the Nation), and if the average family in the plan paid $75 a year, then the State-Federal aid would contribute $38 per family to cover the deficit to that plan.

On the basis of these figures it is apparent that a $3,800 family would be paying its full cost. Smaller incomes would be subsidized, partly by the higher-income people who join the plan and partly out of public funds. Partial subsidization of the low income groups by the higher ones is what happens now, in a rough and unsatisfactory way, through the scaling of charges by the doctors and the hospitals.

The minimum that anyone can pay to participate in a plan is $6 a year. In the case of unemployed persons or public wards this may be paid by the State, for whatever plan the individual chooses. On the other hand, the highest income used for figuring subscription rates is $5,000. Persons with larger incomes may join the plans, and will undoubtedly choose to do so; but many plans will probably provide that such people would be paid fixed sums (called "indemnity benefits") rather than being covered for the complete cost of their care (called "service benefits").

FREEDOM IS PRESERVED

Whether a family decides to come into the most complete plan set up under the State's program in its community, or into a cheaper and less complete plan, or stay out of all of them, is left to its own free choice. Whether a subscriber's employer pays all or part or none of the subscription charge, is for the employer and employee to work out together. Whether a subscriber's contribution is deducted from his pay is also subject to free arrangement. In the case of State and Federal employees, the bill provides that this may be done.

Like their patients, the Nation's doctors are free to come into any plan that will accept them, or to stay out of all of them. No more than at present will they be forced to accept any patients. Their inducement to come in lies in the fact that the services that they now supply free to those who cannot pay their own way, will be fully paid for by the plans, whose members may be these same persons hitherto dependent on medical charity. They will be free to join any sort of plan, including group practice plans, which will be fostered by the bill. Doctors may take part in the formation of a plan, but may not control it.

Hospitals likewise may contract to supply their services to any plan that needs them, or they may stay out. The same inducements apply to them as to the doctors. In supporting the Blue Cross, the country's hospitals have already demonstrated their willingness to take part in prepayment plans.

The advantages of the program will be inducement enough, and no individual or group—consumer, doctor, or hospital—will be compelled to join. The powers and duties of government—local, State, and Federal—will be held to the minimum. At every level there will be ample freedom for that creative initiative which alone can translate our American aspirations into reality.

FEDERAL AID

The basic formula for Federal aid under this bill follows the lines of the Hospital Construction Act. Federal aid will be granted a State in inverse proportion to its per capita income. States having the lowest per capita income will receive Federal aid at a ratio of three Federal dollars for every State dollar devoted to the program; those with the highest per capita income will get one Federal dollar for two State dollars. The average for the Nation will be a little more than 50 percent Federal aid. The ceiling for Federal aid to any given State will be $15 a year for each person covered.

A State will begin to receive its Federal contribution as soon as it has passed the appropriate legislation and as soon as the machinery is in operation.

In the sometimes difficult matter of raising money to start a qualified nonprofit plan, the Federal Government will also help the States to help the organizers. Whatever amount the sponsors of a plan can raise, either by free contribution or in the form of non-interest-bearing loans, will be matched by mixed Federal and State money as interest-free loans.

A separate bill is being filed by the sponsors of this legislation which would make subscription charges deductible from taxable income.

The bill further provides for a revolving construction loan fund of $10,000,000 of Federal money. Without requiring any State participation, this sum will be loaned to cooperating prepayment plans for the special purpose of building and equipping small local medical centers for the group practice of medicine. This sum would provide for the setting up of about 125 new health centers at one time, with no burden on the States.

By these means the establishment of a widespread, diverse system of voluntary plans will be fostered, including those that use group practice. In the long run those plans which supply the best and most extensive medical care for the subscribers, and at the same time obtain the most effective cooperation of the medical professions and the hospitals, will most rapidly spread their influence and increase the number of their subscribers. The mainspring of the program will be competition between the plans in the quality and extent of their services, with free opportunity and incentive to develop ever more effective means of distributing high-quality medical care.

EXPANSION OF MEDICAL RESOURCES

The accelerated development of prepayment plans, and the increased effective demand for medical services which would result from the enactment of this bill, must be matched by a steadily increasing number of well-trained doctors and nurses. The bill, therefore provides special help for medical and nursing education, the cost to the Federal Government ranging from about $25,000,000 in the first year to about $40,000,000 in 1953. Federal aid is provided also for the construction and equipping of additional or new medical school facilities, the Federal funds to match money from other sources.

The development of prepayment plans also makes it necessary to accelerate new construction of diagnostic and personal health service centers as well as hospitals. For this reason the bill offers amendments to the Hospital Construction Act, adding $100,000,000 a year to the present appropriation of $75,000,-

000 to be mixed State by State with funds from any other source according to the formula already described. Diagnostic and health service centers may share in this Federal aid.

The improvement of personal medical care throughout the country does not diminish the need for improved local public-health services. This bill therefore provides for the extension of the established program of Federal aid to the States and local communities for the employment of public-health officers and other personnel, and for the extension of basic community-health services throughout the Nation. This is universally recognized as an integral part of a sound national health program.

Finally, the bill provides Federal aid (in the same proportion to State aid as in the case of prepayment plans) for programs in areas of "special need." Such an area is defined as one in which there are no more than 8 doctors per 10,000 of population. Here it is proposed, with mixed Federal and State funds, to provide immediately the financial incentives and guarantees required to attract to these areas doctors, dentists, and nurses, and to provide the traveling clinics they so sorely need. Such funds will also be used to cover the initial deficits of hospitals, health centers, and diagnostic centers set up in these areas with the help of grants provided for under the Hospital Construction Act, as amended by this bill. This special program is of a largely temporary nature to fill the gap existing before the voluntary prepayment plans can develop so as to take up the burden. At a later stage Federal and State aid will flow into these areas through the normal channels described above.

STUDY AND PLANNING COMMISSION

The sponsors of this bill believe that the program of action described in the preceding paragraphs represents the most that the Federal Government should now undertake in new forms of assistance in the field of health. There remains, however, much more to be done. For the purpose of determining precisely what the Nation's health needs are, and how best to mobilize our resources to meet them, the bill sets in motion immediately a grass-roots inventory of health conditions, health resources, and all aspects of medical research, recruitment, and training of health personnel. For this purpose it establishes a bipartisan commission to be appointed jointly by Congress and the President, to direct, supervise, and coordinate a continuing study conducted locally.

This Commission is to report to Congress within 2 years on their findings with respect to the most pressing problems, such as the financial condition of the country's hospitals, the recruitment and training of health personnel, the provision of care for the chronic diseases (heart disease, cancer, multiple sclerosis, cerebral palsy, poliomyelitis, and other crippling diseases of children, etc.), and the provision of dental care.

Within 4 years the Commission is instructed to report its findings and to formulate a 20-year national health program. In formulating this plan the Commission is to take into account the recommendations of the cooperating local and national organizations. Thereafter the Commission will report every 2 years, at each such interval pushing ahead the 20-year plan by 2 years.

The survey is to be financed by the Federal Government at an annual cost of $5,000,000.

COST AND GROWTH

In all its parts, this bill asssigns the Federal Government the role of assisting local and State undertakings. The bill, in effect, says to the families of America and to their local and State governments, "the National Government offers to back up what you undertake. The scale of Federal aid depends on the scale of your enterprise." Thus, what these programs will mean in terms of Federal appropriations each year will be determined mainly by the scale of the voluntary response the Government's offer gets.

Assuming maximum voluntary response, the bill may be expected to call on Federal revenues for $300,000,000 the first year, and for a possible $850,000,000 4 years hence.

The largest potential expenditure is aid to the prepayment plans. By 1953 the Federal share in that program could reach $500,000,000 a year. This would represent a little more than half of needed public support for these plans, Subscribers' payments should provide between 60 and 85 percent of the plans' costs, depending on the income level of the particular community.

The Federal contribution to the "special need areas" can be expected to rise to a peak of conceivably $150,000,000 by 1952, and thereafter level off at between $75,000,000 and $100,000,000 a year until prepayment plans blanket these areas.

The help offered to medical and nursing schools will probably range from $25,000,000 to $40,000,000 a year from fiscal 1949–50 to 1952–53, respectively. Construction grants to the schools over those 4 years may total $120,000,000, or $30,000,000 a year.

Hospital construction is not likely to take less than the $175,000,000 a year proposed. This is $100,000,000 a year more than is provided by the existing law, under which a large backlog of much needed hospital facilities has built up.

The local public-health units program will probably rise to $30,000,000 by 1952–53 from $15,000,000 in 1949–50.

Comprehensive health study and planning will take $5,000,000 a year.

This added Federal expenditure will represent growth the length and breadth of this country in effective health services. It will also represent additional expenditures by States and local communities which have to spend their money in order to get the Federal money. Indeed, individuals have to decide to spend their money before the Federal or State governments become committed to provide any funds whatever.

BRIEF COMPARISON WITH HILL, TAFT, AND THOMAS BILLS (S. 1465, S. 1581, AND S. 1679)

In principle this approach to health insurance is similar to that of the Hill bill, but with several important differences. One is that the Hill bill in effect requires those who need help in paying for voluntary prepayment plans to pass an individual "means test," while this bill gives everyone the automatic right to join a prepayment plan at a charge that he can afford. On this point, the Taft bill is less explicit but just as clearly contemplates the use of a means test.

Under the Hill bill public aid would go only to prepayment plans offering no more than in-hospital care and the out-patient services of hospitals and diagnostic centers. This bill leaves the scope of services for which public funds may be used solely to the discretion of the States and their health regions. From the beginning people in many communities will secure far broader benefits, such as home care and preventive services of doctors, where the community is equipped to supply them.

Both the Hill and Taft bills fail to provide for the free organization of prepayment plans within the States. At present in 22 States the organization of such plans is effectively restricted to medical societies. In contrast our bill provides positively for State enabling acts which would permit the free organization of prepayment plans.

The Taft bill concentrates all attention on those "unable to pay the whole cost" of care and requires the States to develop programs that would assure such persons all needed services within a period of 5 years. This requirement, we feel, is totally unrealistic in the light of the proposed maximum appropriation of $300,000,000, which, added to State funds, would provide no more than $600,000,000 a year of public funds for this purpose. In our judgment it would take five times as much money and more than 10 years' time to reach the Taft bill's goal.

On this score, the Thomas bill is equally unrealistic. Starting in July 1951, it would impose a pay-roll tax of 3 percent on the employed and an income tax of 2¼ percent on the self-employed, for which there would be given as broad a range of services as the Federal Government believed could be supplied in the various States. But, while theoretically only services that could be provided would be promised, the payment of so substantial a tax would necessarily confer on the taxpayer a right to demand comprehensive care. This insistent demand would force a burden on hospitals, doctors, and auxiliary personnel that they could not possibly carry. The result would be grossly inadequate service and an irresistible demand for direct Federal control. In contrast, this bill links the extension of prepaid services with the local capacity to supply service. There is no element in this bill that will force or encourage public authorities or prepayment plans to issue contracts that cannot in fact be fulfilled.

The Hill, Taft, and Thomas bills all provide for surveys or studies of various elements of the health field. This bill seeks to unite all these partial studies and many others into a single coordinated whole, looking toward the formulation of a national long-range program. There have been too many fragmentary studies and plans. It is time for the health problem to be treated as a single problem, one of the biggest and most basic problems the Nation faces today.

The goal of this bill is the most efficient production and distribution of medical care for the benefit of all the American people. We propose means for moving immediately toward that part of the goal which is realizable with present resources and those that can be developed soon. The survey is intended to amend the means if necessary to develop further means, to state the further goal of covering all the health needs of the American people, and to work out the means of achieving that ultimate goal.

Outline of National Health Act, 1949

The proposed National Health Act, 1949, is developed within the framework of the Public Health Service Act, (*a*) adding a new title VII, which provides an immediate health- and medical-service program, (*b*) adding a new title VIII, which provides for a long-range survey of national health needs, (*c*) amending existing provisions of title VI, relating to hospital construction, (*d*) adding a new provision to title III, regarding local public-health units.

(*a*) The core of the title VII immediate program is part C, providing assistance to voluntary nonprofit prepayment health-service plans. These are the salient features:

1. Individuals will obtain medical care for themselves and their families by belonging to and obtaining a kind of "health insurance" contract through "cooperating prepayment health-service plans" (which are to be nonprofit organizations like the Blue Cross) (721 (b)).
2. These plans must base their subscription charges upon a percentage of the subscriber's net income up to $5,000. The minimum subscription charge is $6 per year (723 (n)). The Health Region Authority—a public body appointed by the Governor—determines to what extent the plans must accept nongroup applicants. Within those limits individual applications must be accepted on a first-come, first-served basis, except that no more than 25 percent of the beneficiaries may reside outside the State (721 (c)).
3. The minimum subscription charges will depend upon the benefits provided by the plan. Section 723 (1) sets forth a yardstick of services and benefits, which include home care, diagnostic and preventive services, and hospital treatment. For this yardstick, the minimum charge is 3 percent of the subscriber's income (723 (n)). If a plan offers greater or less benefits than the norm, the minimum subscription charge is adjusted accordingly (723 (m), (n)). A plan may offer more than one contract.
4. However, it is for the State health council to determine, upon the basis of available personnel and facilities, the maximum range of services and benefits which may be offered by the plans under the program in that State (723 (i)).
5. The Health Region Authority will calculate an "allowed cost," which is its estimate of the normal cost of furnishing the benefits under each approved contract (723 (m)). The State program will assure each plan that it will recover this "allowed cost," and in the event that subscription income is inadequate—whether due to the low income of the subscribers or their greater health needs—the State will pay the difference (723 (i)). An adjustment procedure is provided for plans with adverse "selection factors"—e. g. where a disproportionate number of the subscribers are aged (723 (o)).
6. The States may make noninterest loans to assist in the initial establishment of the prepayment plans (723(y)).
7. The States may make special grants for "special need areas"—defined in 721(i) as regions with not more than eight doctors per 10,000 population—in order to assure the personnel and facilities needed to furnish the services set forth in 723(1) (724).
8. As to all these sums paid by the State, the Federal Government will reimburse the State up to its "Federal percentage" of the sum paid. The "Federal percentage" increases as the State's per capita income decreases, but never falls below 33⅓ or exceeds 75 percent, subject to the qualification that, as to sums paid by the States to participating health-service plans to meet their costs, in no event can the Federal reimbursement to the State exceed $15 yearly per beneficiary covered by such plans (725).

(B) Title VII, part D: Appropriates $10,000,000, so that the Surgeon General may make 4-percent loans to prepayment health-service plans to cover up to 80 percent of the cost of "personal health-service centers" to provide health services to the subscribers and beneficiaries as ambulatory patients.

(*c*) Title VII, part E: to alleviate the shortage of doctors and nurses the bill provides:

1. Payments to medical schools of $500 for each enrolled student, plus an additional $1,000 for each enrolled student in excess of average past enrollment. Comparable provisions are provided for nursing schools (743).
2. The Surgeon General may grant up to 50 percent of the costs of construction and equipment of new medical or nursing schools or expansions (744).

(*d*) Title VIII: Establishes a bipartisan Federal Health Study and Planning Commission—four members appointed by the President; four by the President pro tempore of the Senate; four by the Speaker—in each case at least two from private life (802).

This Commission is to conduct continuing studies of health-service needs, obtaining data as to supply and education of qualified personnel; as to health care received within the various regions; as to status of research, health education, hospitals and health centers, etc. The Commission is directed, so far as practicable, to avoid making its own studies but to develop the basic data through contracts with public bodies established by the States, and with public and private nonprofit organizations (805).

The Commission is directed to formulate a 20-year health plan to improve the Nation's health services. This plan is to be submitted to the President and the Congress by January 15, 1953, and is to be revised every 2 years. The Commission is also directed to make interim reports on certain urgent problems.

For these purposes up to $5,000,000 per annum is authorized for appropriation.

(*e*) Title VI of the Public Health Service Act, Hospital Construction Program, is amended in certain respects:

1. To permit State grants and Federal contributions for construction of diagnostic centers, and personal health-service centers, serving ambulatory patients, as well as hospitals and public-health centers (631).
2. Increases appropriation from $75,000,000 to $175,000,000 per annum, and increases Federal contribution to construction projects from a flat 33⅓ percent to the State's "Federal percentage" (which varies from 33⅓ percent to 75 percent) (sec. 621, 624, 625).
3. Provides $2,500,000 per annum for demonstrations to improve the efficiency and utilization of hospitals and health personnel.

(*f*) Title III is added to by inserting section 315, relating to local public-health funds. If a State provides a plan for extending the coverage and services of local public-health units, it is entitled to receive a percentage of the cost of the plan, the percentage varying inversely with the State's per capita income but not exceeding 66⅔ percent.

Senator **Flanders**. The bill does not bring about "socialized medicine." On the contrary, it very greatly encourages the development of private efforts.

It invokes no "means test"; on the contrary, it offers to everybody, poor or well-to-do, the right to obtain the same services as everyone else at a cost scaled to his means.

The sponsors consider the bill to be realistically designed to bring within everybody's reach all the care that the Nation's medical facilities can provide, and to assure the rapid development of enough facilities to include everybody in every income group who wants to use them. It thus places itself squarely in the American tradition of more and better services in response to voluntary demand.

The key to the program is the local, voluntary prepayment health-service plan. Many such plans already exist—Blue Cross, Blue Shield, innumerable group health plans, industry plans, labor-union plans, welfare funds, cooperatives, and so forth. Over 35,000,000 people are already enrolled in these plans.

The chief disadvantage is that the flat-rate premiums which most of the plans must now carry are beyond the means of millions of otherwise self-supporting people. This is especially the case when doctors' services in the home and office, preventive medical care, as well as hospital services, are included. Premiums for such coverage may run from $100 to $150 per family, far too much for incomes in the lower brackets. As a result, only a few of the voluntary plans at present cover more than hospitalization and surgical care, a fragment of the health services people need.

This legislation contemplates hundreds of such nonprofit voluntary plans, each locally organized and operated. It will use existing plans, enable them to expand, and open the way for new plans throughout the country.

Fundamental to the program is the requirement that these voluntary plans base the rate of payment by subscribers upon a percentage of the subscriber's income (up to $5,000). This provision will necessitate changing the method of charging practiced by most plans at present in existence. It is, however, essential for the purpose of opening voluntary plans to everyone by bringing in public aid for people of limited income without a means test.

Senator MURRAY. Excuse me, Senator. It is contemplated under your plan that all people will join these voluntary plans?

Senator FLANDERS. Yes, sir.

Senator MURRAY. And those who cannot afford to pay the premiums that are required will be assisted by payments from the Government?

Senator FLANDERS. It is the idea that they do pay a percentage of their income, but that will be very low for those of low incomes—the percentages that they can afford—and that the Government provision will make up the difference between what they pay and what they get—the cost of what they get, that is, of course. I may say, Mr. Chairman, that I have had correspondence with some people criticizing this notion of the poor turning in low payments and the well-to-do higher payments. But that exactly follows the present practice whereby the well-to-do now pay for the poor—by paying higher rates for operations, by paying higher fees to doctors, and, in general, paying more than their cost of the treatment that they get—so that the medical fraternity and the hospitals may render a large measure of free services to the very poor.

Senator MURRAY. Of course, that is not under any governmental regulation.

Senator FLANDERS. No.

Senator MURRAY. And the doctor, for instance, could charge a fee of $5,000 for an operation, but that does not mean that any part of that $5,000 fee is going to go to taking care of people who are unable to finance their operations.

Senator FLANDERS. That is not formalized in any way. It is not assured and it is not legalized. But, fortunately, it has, I believe, been medical practice for generation after generation to offer services to the very poor which they cannot pay for and which are indirectly financed by these higher fees to the well-to-do.

This, however, organizes the practice and puts the Government's support behind it.

Senator MURRAY. Of course, the system you are talking about is a very vague and uncertain one, and very few people get any advantage out of it.

My understanding is that the person who is too poor to pay for it does get very little of the kind of medical care that goes to those people who can afford to pay.

Senator FLANDERS. But it has been my observation—and I must admit it is limited, being confined to some of the hospitals, and so forth, of my own State, in which I had an interest—that it is the practice.

Senator MURRAY. Do I understand that your system is a sort of compulsory system or is it a voluntary plan?

Senator FLANDERS. That is a voluntary system of a compulsory system. [Laughter.] Now, I might say here, that I have observed as to medical care and hospitalization that the very poor got better attention and better treatment than the moderately well-to-do, to whom a heavy hospital or operation expense comes as a calamity. There is in their case not the same history of a practice of free treatment, for those in the lower-middle incomes, for those in that group, that there is for the very poor. That has been my observation.

Mr. HERTER. Do you mind, Mr. Chairman, in view of this other obligation I have, if I say a word at this point?

Senator MURRAY. Proceed.

Mr. HERTER. I might say on behalf of the House Members that there were other Members who filed bills identical with the one filed by Senator Ives and Senator Flanders—Congressman Case of New Jersey; Congressman Auchincloss, of New Jersey; Congressman Javits, of New York; Congressman Nixon, of California; Congressman Morton, of Kentucky; Congressman Fulton, of Pennsylvania; and Congressman Hale, of Maine.

During the course of our work on this bill we had the skilled and trained services of Mr. Winslow Carlton, who is here this morning and will answer your questions later. I am sure you will want to interrogate him with respect to the details of this bill. I think they are very well set out in Senator Flanders' statement here before you, as well as in the statement which you have allowed me to place in the record.

There are two principal points I would like to stress in this very brief testimony I will give. The first is that the whole concept of this bill is based on furnishing the maximum which existing facilities make available.

I can think of no greater fraud which could be perpetrated on the people of this country than to tax them for services which cannot be delivered. In other words, these voluntary plans can extend medical services only to the extent that medical services in the form of doctors, nurses, technicians, and so on, are available.

Senator PEPPER. Senator Flanders, did you want to finish your statement?

Senator FLANDERS. Mr. Herter has to leave. I will resume after he is finished.

Senator PEPPER. I see. I would like to ask the Congressman a question just at that point. They are not going to write any more insurance policies than the facilities can take care of; is that the contemplation?

Mr. HERTER. Certainly not. To do that would be perpetrating an absolute fraud on the people and saying to them, "For your money we will give you so much," when the facilities are not available.

Senator PEPPER. Then, do you contemplate making an estimate of the number of those people who can receive medical care under the plan and contemplate holding yourself to accepting just that many subscribers?

Mr. HERTER. Either that, or cut down on the services. That is, in other words, the prepayment plan can cut down the amount of services they can offer, based on the facilities available.

Senator FLANDERS. At the same time, the bill will take care of that, by providing for the expansion of facilities.

Senator PEPPER. Fortunately, we are all agreed on that point; we are all agreed that we have got to expand our facilities.

Senator FLANDERS. Yes.

Senator PEPPER. Both Houses and both parties are in agreement that we do need a great many more doctors and many more nurses, as well as technicians and hospitals, and all those things.

Mr. HERTER. The provisions of the bill are similar to the other bills filed, in that all of them provide for increasing hospital facilities, and for increasing the number of medical students, and so on.

Senator MURRAY. I believe it has been demonstrated and it is admitted by you that there is need for the expansion of medical care.

Mr. CASE. We allege it; we do not admit it.

Mr. HERTER. But consideration of that problem is not merely confined to the over-all needs. We have a spotty situation in this country, wherein there is a great unevenness in the field. For instance, a statement was made that impressed me, that 80 percent of all the endowments for medical care—or for hospitals—lie in an area between Boston and Baltimore on the Atlantic seaboard.

Now, that obviously means that your hospitals and facilities elsewhere, have the other 20 percent, and that means that they have had comparatively little in the way of a backlog, from the point of view of endowment or other aid, other than in those which received either State grants or else collect money annually from charitably minded individuals.

Senator PEPPER. If I might inquire into the plan a little at this time.

Senator MURRAY. Yes.

Senator PEPPER. Your plan does not contemplate requiring anybody to take out the insurance?

Mr. HERTER. It does not require anybody. Presumably, it will be the idea to make it so attractive that they will—attractive enough so they will want it. But nobody has to do that.

Senator PEPPER. Well, now, I am just trying to get at the bottom of this thing, particularly with respect to those parts of it that are different from the national health insurance plan.

Do you base the amount that each should pay upon the person's income?

Mr. HERTER. That is right, it is based on a percentage of the income.

Senator PEPPER. Now, you pay a percentage of your income?

Mr. HERTER. That is right.

Senator PEPPER. Our plan is based on payments from income. In yours you pay a fee based on income?

Mr. HERTER. That is right. That percentage, however, would vary with the amount of service that you were buying.

Senator PEPPER. I think that is true under the other plan.

Now, supposing it starts off with a one-half of 1 percent charge, if that is the amount of the pay-roll tax. It is contemplated that as more services become available, that will be increased?

Mr. Herter. Yes; but our plan allows a much greater flexibility. You can adapt it to local conditions, which vary tremendously.

Senator Pepper. You propose to make up to him the difference between what the subscriber pays and what the care rendered will cost, by funds of the several States; is that right? They will have to make up that difference.

Mr. Herter. That is right.

Mr. Case. Not to the person, sir; the plan.

Senator Pepper. I did not understand.

Mr. Case. Not to the person, but to the plan. The person pays only to the plan the percentage of his income. The plan gets the money.

Senator Pepper. You pay the insurer. Then, the next thing: Does the Government have anything to do with the operation of the voluntary insurer?

Mr. Herter. The Government as such has nothing to do with that.

Senator Pepper. The Government does not pass on the efficiency of the operation, or the character?

Mr. Herter. The local people determine that entirely. They have to certify to the Federal Government that a particular plan meets certain minimum specifications.

Senator Pepper. Do you include your commercial insurance companies?

Mr. Herter. No; it has to be nonprofit organizations.

Senator Pepper. Would you include a mutual insurance company of a private character?

Mr. Herter. I am not sure we would include mutuals or not. Frankly, the word "insurance" as such has been, I think, somewhat of a misnomer here. In other words, it is a prepayment plan rather than an insurance plan. You cannot insure on a flat-fee basis.

Senator Pepper. Who would select the doctor?

Mr. Herter. That is up to the prepayment plan itself.

Senator Pepper. The prepayment plan—that is, the insurer, the voluntary insurer, or what you would call the insurer or the agent—the one that renders the service?

Mr. Herter. We call it the plan, the prepayment plan.

Senator Pepper. Yes; let us say the agent of the prepayment plan. Would the patient have free choice of doctors and hospitals and dentists and nurses and that sort of thing?

Mr. Herter. That would depend on the plan. Some plans would offer group facilities, which would not necessarily allow a choice, under which they would have their own staff, for their clinical facilities, full-time services of a group of physicians. In offering that particular plan to the individual, they would be limited to that group.

Senator Pepper. And your Government funds would be available to any approved agent, let us say, that might have a group of doctors for a group of people, for a voluntary nonprofit insurance group?

Mr. Herter. It might be organized by a labor union for its own members and be approved in that way, as some of them are today. Some of the unions such as the Ladies' Garment Workers have well-organized health-service plans, and in New York they have very good medical-care facilities now.

Senator PEPPER. My last question is with regard to the fee for the services. I did not really mean to interrupt, but I thought it might clear up a few points.

Would the agent of the plan determine the amount of the fees that the doctors would charge?

Mr. HERTER. It would be negotiated through the hospitals, as is done today by the Blue Cross and the Blue Shield.

Senator PEPPER. Well, the doctor in that case, you think, will not claim it is interference with his freedom?

Mr. HERTER. Not at all. Not a single doctor has to accept those fees.

Senator PEPPER. In that respect, it does differ from the national health-insurance plan.

Mr. HERTER. No, I think under the national health-insurance plan—and I am subject to correction here—if you have everybody covered, the doctors cannot very well perform services except for a limited number of people willing to pay outside the plan.

May I just add one thing? I want to emphasize the importance, in my opinion, of title 8 of section 8 in this bill which provides for a continuing Commission.

Mr. CARLTON. Title VIII, section 802.

Mr. HERTER. It is a bipartisan Commission known as the Federal Health Study and Planning Commission, which would be set up, with four members appointed by the President of the United States, four by the President of the Senate, and four by the Speaker of the House.

There is a misprint in that section. It says:

> (g) There is hereby authorized to be appropriated for each fiscal year * * * (not in excess of $30,000,000 for any such fiscal year) * * *.

That should be $3,000,000.

Mr. JAVITS. I think it is $5,000,000.

Mr. CARLTON. $5,000,000.

Mr. HERTER. Yes. The figure should be changed. Unfortunately, it was not corrected when it went to the printer, and it looks like an excessive amount.

But certainly I feel that that Commission is of the utmost importance if we are going to be able to progress intelligently in this whole field. It will make a continuing study possible not through the creation of a very large Federal staff but through contracting insofar as possible with the voluntary organizations, technicians, and experts through the States and municipalities in order to get an over-all picture of the facilities available and personnel available, and so forth, in all sections of the country.

I think that kind of a survey is of the utmost importance, even if nothing else is done, in order that progress might be made as intelligently as possible in the future.

Senator MURRAY. Your plan contemplates the Government making up the deficiency in funds to carry out the program; does it not? That is, you would get annual appropriations from the Government to aid in carrying out of your program?

Mr. HERTER. That is right.

Senator Murray. And what provisions have you for guarding the use of those Federal funds? Is there any set-up in your plan whereby the Federal contribution should be supervised or controlled?

Mr. Herter. There are certain limitations that are put on the amount of Federal contributions that can be made; but we are relying in very large measure on the honor of the various governors of the States in the certification either directly or through the health councils with respect to the cost of the work that is being done.

Senator Murray. You would leave that in the hands of the governors?

Mr. Herter. The Surgeon General is sitting on top of the entire situation. Any time he is not satisfied, he can come to the Congress and say not to appropriate any further funds.

Mr. Javits. There is also a post-audit control, I want to point that out.

Mr. Carlton. That is right; there is a post-audit.

Senator Pepper. Gentlemen, I am glad to have you very able and distinguished and prominent Members of the House here, as well as our distinguished colleagues in the Senate.

I am now only speaking for myself, although I feel sure others feel the same way, but I am certainly interested in seeing something started at the soonest possible date. And I have thought of several different ways of making a beginning. I am thinking more particularly of getting something through this session of the Congress, and wondering what that something might be. If we can get something through this Congress, then I think we can probably get some later.

Now, as one of those things I think we might be able to get through Congress now, probably, is this. I think we can possibly get some aid for medical schools; do you not, gentlemen? Do you think you can get a bill out on your side to give some Federal assistance first to the construction of new medical schools, or to the expansion of old medical schools, and aid in operating such medical schools as we now have?

Mr. Herter. I think that question ought more properly be addressed to another group.

Mr. Case. I understand the Committee on Interstate and Foreign Commerce of the House is interested in that, and some of the other Members.

Senator Pepper. We might be able to get that out, as well as some hospital bill, getting some funds for a hospital program, and for research, and so on.

But, now, what would be your reaction to a bill that applies national health insurance just to hospital care—that is, it would be compulsorily imposed, but just to cover that aspect for the time being? It would apply to nothing except the rendition of hospital care to the covered people.

That might be something that should not involve so much the professional people. It would not even cover, in the question I am assuming, it would not even cover the rendition of medical care in the hospitals, but would cover simply hospital services for all the covered people.

I thought that might furnish us a basis upon which we could experiment and see how it works. Hospitals are covered anyway, mostly, and it would still leave room for these voluntary plans and not touch the matters of rendition of medical care in the hospitals and in the doctor's office and in the patient's home. What is your reaction to that?

Mr. HERTER. I do not know, sir. I think a great deal of it would depend upon——

Senator PEPPER. What would be your reaction to such a proposal, though?

Mr. HERTER. I would be very hesitant to offer any off-hand opinion. I would want to have the opinion of Mr. Carlton here, who is an expert in this field. He is present and he has given real thought to all the consequences of a compulsory system, which will, of course, require the Federal Government to have some supervisory authority.

Senator PEPPER. I am not talking about that. You gentlemen do not contemplate Federal control for the agencies or for use of Federal funds, and I do not see that you need push us about it. We are not talking about Federal control of the hospitals at all, except that they might be under the same general sort of supervisory authority that your bill contemplates.

But I am thinking of the function of the Federal Government. It would be to impose the tax and lay down certain very broad and general standards. Now, as to those standards, I would be perfectly willing myself to have in the law that the standards of the American Hospital Association would be the standards of control, and that any hospital that these health authorities say meets those standards would be eligible for inclusion in the plan.

Mr. JAVITS. Senator, may I make a suggestion?

Senator PEPPER. Yes; from any of you gentlemen.

Mr. JAVITS. Senator, I may observe right here and now that there is one inherent point in our whole idea or even in the idea of the Senate, with what they are concerned. That is this, that in any such plan a very substantial appropriation of Federal funds is always considered necessary. As to the figure, generally speaking it is in terms of maybe a billion dollars of Federal funds to supplement the payments.

Senator PEPPER. You mean, just for hospitalization?

Mr. JAVITS. No; the general plan. We subscribe to two things which we consider very important and which narrow the area of difference.

First, we subscribe to the acceptance of national responsibility in this field.

Senator PEPPER. Good.

Mr. JAVITS. And secondly we subscribe to the implementation of that national responsibility, in the sense of building up the facilities. They need to be builded up.

Senator PEPPER. Yes.

Mr. JAVITS. And there we are all with you, and you are all with us, and we are all together. We join with you in that. The place where apparently the difference comes is where you require tax payments and in defining the terms, the services assured.

It seems to us we would go all the way through with no trouble with the House, in my opinion—of course, we are not the Democratic leadership—on questions of aid to medical education to the medical schools, and on questions of aid to hospitals in their deficiency problems today.

But, the minute you go to a payment plan or tax plan, even if it is confined to the hospitals, you will be in the same row, in my opinion, you will be subject to the same delays.

So, if you do want to supplement the hospital deficiencies, from my own point of view—and I say this respectfully, the Senators know the respect we hold, and we have had contact before—I say you do not want, I think, to get into any big discussion about any tax-payment plan, even if it is only as little as one-half of 1 percent, because that will be immediately taken as the fundamental operation, and you will have the battle you have today.

Senator PEPPER. Very well. There remains another possibility I just want to explore.

Would the Congress, in your opinion, be willing to propose that any State which should wish to impose through its own legislature or wished to take advantage of a national health insurance plan, do you think that the Congress would levy the required payment just as we do in the case of unemployment compensation, where the Federal Government levies the tax and the State has the system under its regulation? I was just thinking if in case the State so provided, whether Congress would say, "A tax is hereby levied and the plan is put into effect in any State which by the resolution of its own legislature desires to come under the plan and put it into effect in its own State," so that if any State is willing to undertake the experiment we would then have, if it did not start all over the country at the same time, some area for experimentation, to see how it would work.

Mr. JAVITS. Senator, it would be my view that there would be much more of a chance, and I think it would facilitate the chances considerably, if the States were given the alternative of trying this plan or ours.

Senator PEPPER. Is there any difference? You let the individual covered pay for his coverage according to his income, and we do the same thing under the national health insurance plan. The only thing is, you make it voluntary as to whether the man comes into it or not.

Mr. JAVITS. That is right.

Senator PEPPER. And we require him to come in, by the law itself.

Mr. JAVITS. That is right.

Senator PEPPER. Now, in addition to that, you make up the difference between what he pays and what the rendition of the care he is to receive costs—without, as far as I have heard so far, your determining what percentage of the total cost the total number of covered people are proposed to pay.

Have you come to any conclusion as to the percentage of the cost of the care to be given is to be paid by the Federal and State governments?

Mr. JAVITS. The amount of care is the regulating point.

Senator PEPPER. Well, whatever you provide. Suppose you propose to give X amount of care. Now, what percentage of the total cost of the total X care given is to be paid by the total number of subscribers?

Mr. JAVITS. The total number of subscribers will pay and the State and Federal Governments will pay on the matching formula, which is the same as the matching formula in social security.

Mr. CARLTON. No.

Senator PEPPER. Well, but what part of the funds under the plan are to be public funds?

Mr. JAVITS. The public funds are the difference between the cost of operating the plan and what the subscribers pay. It is limited to a

Federal contribution of up to $15 per person and a State contribution to match that.

Senator PEPPER. You are going to give every subscriber $15?

Mr. JAVITS. If the plan has a deficit. If there is that deficit, then you make up the plan's deficit to the extent that particular plan has a deficit, the Federal and State Governments make it up in the way I have described.

Senator PEPPER. Then, are the people who run these plans going to have to determine what percentage to charge?

Mr. JAVITS. Yes.

Senator PEPPER. And how will they determine? You lay down the standard?

Mr. JAVITS. Yes; you lay the standard in the bill.

Senator PEPPER. And what is that standard?

Mr. CASE. The so-called yardstick. Generally speaking, they may charge 3 percent.

Senator PEPPER. You are going to charge 3 percent of the covered person's income?

Mr. JAVITS. Up to $5,000.

Mr. CARLTON. Up to $5,000.

Mr. JAVITS. More or less—they must charge more or less in percentage.

Senator PEPPER. The 3-percent charge would cover complete coverage?

Mr. CASE. Complete hospital out-patient coverage preventive medical care and remedial medical care at home.

Senator PEPPER. And in the doctor's office?

Mr. CASE. In the doctor's office, that is right.

Senator PEPPER. And would include dental care?

Mr. CASE. Not at this point.

Senator PEPPER. Does it include medicine?

Mr. CARLTON. No.

Senator PEPPER. And it does include wigs?

Mr. CARLTON. No.

Senator PEPPER. They do include wigs in Great Britain.

Senator FLANDERS. If this does, I am a candidate. [Laughter.]

Senator PEPPER. It has been pointed out that they just do not give a wig, as I understand it, to everybody who has lost his hair, but when it is the result of a disease. But that is perhaps about as good a public expenditure as are many others that are made, and I do not see any reason to ridicule that expenditure for wigs.

Well, is there any limitation as to the time the patient can stay in the hospital under your plan?

Mr. JAVITS. That depends on what the local facilities will permit.

Senator PEPPER. All right, then assume that the local facilities will permit it. Is there any limitation?

Mr. JAVITS. Assuming whatever the facilities will permit, the plan is privileged to include that.

Senator PEPPER. You do not have any tax on the employer, is that so?

Mr. JAVITS. No.

Senator PEPPER. The whole contribution comes from the employee?

Mr. JAVITS. I am glad you mentioned that, Senator, and I think your questions have been admirably suited to bring this out. When you really boil down the differences between our plan and yours, it comes to this compulsory employer-employee contribution. You can do everything with our plan, and do it for the self-employed and everybody who pays this 2½ percent or 3 percent, that you can with the administration plan, so-called. Both plans will do it.

Now, where you run into the really sharp difference is on this question of compulsory employer-employee contribution. That you cannot do under our plan except by collective bargaining.

There is where you have the whole weight of the difference, and that is where you must balance it against such things as the opposition of the doctors, the question of centralization or whether you want the maximum of decentralization, whether you want central or local management of the plan. And there is the question whether you want to preserve the quality of medical care instead of having it handled on a quantity basis. All those things you have to balance.

Senator PEPPER. You also have to take into account, while you are balancing these interests, the number of people who in the nature of things—people being what they are—will benefit from one plan as against the other.

And a second thing you would have to take into account is the question as to whether the Federal and State Governments would be disposed to turn their money over to a group of private citizens who have no responsibility, evidently, from the provisions of the plan, as regards the services to be performed for those funds.

Mr. CASE. May I make this point in connection with this, that the thing is wholly controlled by the State and the State council set-up—official bodies.

Now, it was said before, that the State and Federal Governments made up the difference between the cost and the income of the plan from the subscribers.

Now, that is not quite true. It is not the actual difference, it is the difference between the plan's income and what the local and State councils say should be the cost for the services which in any particular case they plan to render. So, it is not actually as was first said; and the plans cannot benefit from Government funds until they are efficiently operated.

Senator PEPPER. You see, there is a great deal of criticism against the national plan because there is the tax and there have to be safeguards and there have to be general standards. And yet I have not heard anybody yet that attacked that who did not run into that same thing. If you are going to use public funds, you have got to lay down some standards, and to see that you pay them on the basis of the service and what that service costs, which means that you are not going to let the doctors and the hospitals have the freedom of charging whatever they want to charge. And yet when the national health insurance plan said it was contemplated there would be negotiations between the doctors and the hospitals, some people just shouted to high heaven that it was Federal regimentation.

Mr. CASE. The idea behind our plan is to have competition between these plans so as to supply the most for the money. That is what we want to encourage, and in that respect we think the voluntary plan has great merit.

Senator PEPPER. Now, you get away from the means test by simply using a percentage of the income of a person.

Mr. CASE. That is exactly right.

Senator PEPPER. And a person that does not have any income, what do you do with that person?

Mr. CASE. Well, we provide for that a special provision under the bill by which a flat minimum can be paid in unusual cases.

Senator PEPPER. And what do you do with the others?

Mr. CASE. They pay a percentage of their income.

Senator PEPPER. Gentlemen, it is very gratifying to see, coming from so many different directions, our distinguished chairman, Senator Murray, getting so much general encouragement. A few years ago when he and Senator Wagner and some of those other pioneering people ventured into this field, if the Senator had not been so enviably well-off economically himself, and if Senator Wagner had not also been, a lot of folks would have believed some of the things they said a lot sooner than they did.

But from all different directions there come now various proposals in this field, and it is fine to see that there are so many minds working on this problem.

Senator IVES. All we have to find is the lowest common denominator.

Senator PEPPER. That is one of the problems to work out, yes. We must reach the best agreement we all can get, and move on from that to the next step.

Personally, if I live out my expectancy, which I am heartily in favor of——

Mr. CASE. And we all are.

Senator PEPPER. I venture to say I will live to see the day when we will be gradually moving towards the principle of national health insurance. I do not know when we will get there, but I feel we are getting there.

Senator IVES. Well, Mr. Chairman, if we get as far as the point where we are apparently in agreement, we will be making quite some progress—quite a lot of progress.

Senator PEPPER. Yes, quite a lot of progress.

I hope we can all work together to get all we can in this matter as soon as possible, get all we can done in this session of the Congress, because a lot of people are going to suffer if we do not get all we can get now.

Mr. JAVITS. We certainly agree. Now, Mr. Chairman, if you will forgive us, we are due in the House.

Senator MURRAY. Yes. Do you want to continue with your statement, Senator Flanders?

Senator FLANDERS. I want to call attention to one other difference between this and what you might call the immediate and full application of the national insurance plan that was mentioned earlier.

That is this, that you might be able to install a full and complete national compulsory health-insurance plan—and not be able to deliver, simply because the facilities are not available over vast stretches of this country. And one of the things that is taken care of in this bill is just that, that we shall not promise to deliver more than we have to deliver. It seems to me that is an exceedingly important difference.

At the same time, we want to make provision that there be increased in the deficit areas the services and facilities that are needed.

Senator **Pepper**. Your plan then would be distinguishable from some of the other voluntary plans, which I understand do not limit the number of their subscribers to the facilities, is that not true?

Senator **Flanders**. Yes, sir. Mr. Carlton, is that not true?

Mr. **Carlton**. The voluntary plans that are now in effect are set up on a local basis, to supply the services the locality can provide. There is a self-limiting factor.

Senator **Pepper**. With reference to the group plans, do they make a careful analysis of the doctors and the hospitals available and say, "We can take in 40 more. You ought to come in while you can, or you might find that we cannot take in any more after you decide to come in."

I never heard of anybody being turned down. Do they turn down anybody?

Mr. **Carlton**. Actually, the group health in Washington long had a waiting list.

Senator **Pepper**. Do you know of any case where the Blue Cross turned anyone down?

Mr. **Carlton**. I do not; but I also do not know of any Blue Cross or Blue Shield set up in an area that was not able to provide services.

Senator **Pepper**. I do not know of any area that is qualified today to furnish all the services to all the people in that area; is that not a fact?

Mr. **Carlton**. The limitations of the plan, sir, are at the present time different from the limitations that would apply under the bill that is now before you. The States and their health councils and health authorities would have to give very serious consideration to the effect of the set-up, to the scope of service before permitting the establishment of any given service in the light of what they could actually there give.

Senator **Murray**. Go ahead, Senator.

Senator **Flanders**. I might say I am informed there are now or have been waiting lists on voluntary plans in effect in the city of Washington, due to restrictions on the amount of service available.

Now, Mr. Chairman, some of the remaining paragraphs of my statement have already been covered, but I note that there is quite a number of other and new points to be brought out still, so I will continue to read the statement.

The bill sets up a national yardstick in the form of a comprehensive range of benefits, which it defines in detail and which includes the most vital health services. It further states that the subscription charge for this particular coverage cannot be less than 3 percent of the subscriber's income up to $5,000.

Any plan which provides the "yardstick" range of benefits will receive from the State (with Federal participation) the difference between its subscribers' payments and the estimated normal cost of the coverage. A plan may offer a coverage less comprehensive than the national "yardstick" coverage, in which case it would charge proportionately less to its subscribers and any public contribution would be based on a proportionately lower allowed cost. Or a plan may provide a still more comprehensive coverage, in which case it must charge proportionately more and would have a proportionately higher allowed cost.

Whether a family decides to come into the most complete plan set up under the States' program in its community, or a cheaper and less complete plan, or stay out of all of them, is left to its own free choice. Whether a subscriber's employer pays all or part or none of the subscription charge, is for the employer and the employee to work out together. Whether a subscriber's contribution is deducted from his pay is also subject to free arrangement. In the case of State and Federal employees, the bill provides that this may be done.

Like their patients, the Nation's doctors are free to come into any plan that will accept them, or to stay out of all of them. No more than at present will they be forced to accept any patients. Their inducement to come in lies in the fact that the services that they now supply free to those who cannot pay their own way, will be fully paid for by the plans, whose members may be these same persons hitherto dependent on medical charity.

Hospitals likewise may contract to supply their services to any plan that needs them, or they may stay out. The same inducements apply to them as to the doctors. In supporting the Blue Cross, the country's hospitals have already demonstrated their willingness to take part in prepayment plans.

The basic formula for Federal aid under this bill follows the lines of the Hospital Construction Act. Federal aid will be granted a State in inverse proportion to its per capita income. States having the lowest per capita income will receive Federal aid at a ratio of three Federal dollars for every State dollar devoted to the program; those with the highest per capita income will get one Federal dollar for two State dollars. The average for the Nation will be a little more than 50 percent Federal aid. The ceiling for Federal aid to any given State will be $15 a year for each person covered. A State will begin to receive its Federal contribution as soon as it has passed the appropriate legislation and as soon as the machinery is in operation.

The bill further provides for a revolving construction loan fund of $10,000,000 of Federal money. Without requiring any State participation, this sum will be loaned to cooperating prepayment plans for the special purpose of building and equipping small local medical centers for the group practice of medicine. This sum would provide for the setting up of about 125 new health centers at one time, with no burden on the States.

The establishment of a widespread, diverse system of voluntary plans will be fostered. The mainspring of the program will be competition between the plans in the quality and extent of their services, with free opportunity and incentive to develop ever more effective means of distributing high-quality medical care.

The accelerated development of prepayment plans, and the increased effective demand for medical services which would result from the enactment of this bill, must be matched by a steadily increasing number of well-trained doctors and nurses. The bill, therefore, provides special help for medical and nursing education, the cost to the Federal Government ranging from about $25,000,000 in the first year to about $40,000,000 in 1953. Federal aid is provided also for the construction and equipping of additional or new medical school facilities, the Federal funds to match money from other sources.

The development of prepayment plans also makes it necessary to accelerate new construction of diagnostic and personal health centers as well as hospitals. For this reason the bill offers amendments to the Hospital Construction Act, adding $100,000,000 a year to the present appropriation of $75,000,000 to be mixed State by State with funds from any other source according to the formula already described. Diagnostic and health service centers may share in this Federal aid.

The improvement of personal medical care throughout the country does not diminish the need for improved local public health services. This bill therefore provides for the extension of the established program of Federal aid to the States and local communities for the employment of public health officers and other personnel, and for the extension of basic community health services throughout the Nation. This is universally recognized as an integral part of a sound national health program.

Finally, the bill provides Federal aid (in the same proportion to State aid as in the case of prepayment plans) for programs in areas of "special need." Such an area is defined as one in which there are no more than eight doctors per 10,000 of population. Here it is proposed, with mixed Federal and State funds, to provide immediately the financial incentives and guaranties required to attract to these areas doctors, dentists, and nurses, and to provide the traveling clinics they so sorely need. Such funds will also be used to cover the initial deficits of hospitals, health centers, and diagnostic centers set up in these areas with the help of grants provided for under the Hospital Construction Act, as amended by this bill. This special program is of a largely temporary nature to fill the gap existing before the voluntary prepayment plans can develop so as to take up the burden. At a later stage Federal and State aid will flow into these areas through the normal channels described above.

For the purpose of determining precisely what the Nation's health needs are, and how best to mobilize our resources to meet them, the bill sets in motion immediately a grass-roots inventory of health conditions, health resources, and all aspects of medical research, recruitment, and training of health personnel. It establishes a bipartisan commission to be appointed jointly by Congress and the President, to direct, supervise and coordinate a continuing study conducted locally.

This Commission is to report to Congress within 2 years on their findings with respect to the most pressing problems, such as the financial condition of the country's hospitals, the recruitment and training of health personnel, the provision of care for the chronic diseases (heart disease, cancer, multiple sclerosis, cerebral palsy, poliomyelitis, and other crippling diseases of children, etc.), and the provision of dental care.

Within 4 years the Commission is instructed to report its findings and to formulate a 20-year national health program. In formulating this plan the Commission is to take into account the recommendations of the cooperating local and national organizations. Thereafter the Commission will report every 2 years, at each such interval pushing ahead the 20-year plan by 2 years. The survey is to be financed by the Federal Government at an annual cost of $5,000,000.

Is that $5,000,000 correct?

Mr. CARLTON. That is right.

Senator FLANDERS. In all its parts, this bill assigns the Federal Government the role of assisting local and State undertakings. The bill, in effect, say to the families of America and to their local and State governments, "The National Government offers to back up what you undertake. The scale of Federal aid depends on the scale of your enterprise." Thus, what these programs will mean in terms of Federal appropriations each year will be determined mainly by the scale of the voluntary response the Government's offer gets.

The bill reflects the belief of its sponsors that great social needs can be met without falling into the errors of state socialism, and that needed services can be given at needed cost to our people without disrupting—but on the contrary, encouraging—the development of private initiative and enterprise.

Senator PEPPER. Any questions, Senator Donnell?

Senator DONNELL. No.

Senator PEPPER. Senator Ives?

Senator IVES. No.

Senator PEPPER. Thank you very much, Senator Flanders; you have made a most interesting and valuable contribution.

Senator FLANDERS. Mr. Carlton has a statement here which he can either read or put into the record . I suggest that if you have some particular points, Mr. Carlton, you feel have not been covered, perhaps the committee would be willing to listen.

Senator PEPPER. We will be very glad to listen to him.

Senator IVES. I want to thank the committee, Mr. Chairman, and I want it understood that I heartily endorse this plan.

Senator PEPPER. Thank you, Senator, we are very grateful to have you come here.

Mr. Carlton, you go right ahead.

STATEMENT OF WINSLOW CARLTON, MEDICAL CARE CONSULTANT, NEW YORK, N. Y.

Mr. CARLTON. There were only a few points raised in the course of the earlier discussions that perhaps might be useful to comment on.

You raised the question of compulsory hospital insurance only. It is my understanding that nationally we are very short of hospital facilities, and we are certainly short of adequate nursing and technical personnel.

A hospital is only as good as its personnel, and that shortage is the reason why all of these bills—I must except the Taft bill—your bill, Senator, and Senator Flanders', provides aid for nursing education.

Senator PEPPER. Let me interrupt you right there. What is the difference between the Flanders and the Hill bill?

Mr. CARLTON. There is very substantial difference, sir. In the first place, the Hill bill would provide aid directly to the individuals who are unable to pay the full cost of their care, or the cost of a prepayment premium.

Senator PEPPER. Leaving it up to the States to determine the measure?

Mr. CARLTON. That is right. But clearly the Hill bill involves a means test. It means that an individual who needs, or believes he needs help, has to appear before a public agency and prove his need. As was brought out earlier this bill avoids that.

In the second place, the Hill bill's initial program is limited to, in effect, in-hospital care, although provision is made for out-patient service for presumably those for whom the public pays.

In the third place, those who do receive assistance under the Hill bill receive it not through insurance but on the basis of the public paying the direct costs of the services, that payment being channeled through a community insurance plan. But there is no element of insurance in that set-up, and in my opinion that would result in the establishment or continuation of a separate type of medical care for the medically indigent.

Senator PEPPER. As I understand your plan, again, the covered person pays not less than 3 percent for complete coverage?

Mr. CARLTON. That is right, sir.

Senator PEPPER. May he be required to pay more than 3 percent of his income up to $5,000?

Mr. CARLTON. It depends upon the coverage of the plan, sir.

Senator PEPPER. Have you worked out any formula to determine the percentage of the total cost of the total care given that is to be paid out of the public funds, Federal and State?

Mr. CARLTON. I hesitate to say I have worked out a percentage, because there are too many unknowns and too many variables. My best guess is that on the basis of the yardstick set up in this bill, the proportion of the total cost that would be met by mixed Federal and State funds would range from 25 percent to 35 percent of the total cost.

Senator PEPPER. You see the fees you fix will, of course, determine probably the degree of the deficit. You may have to learn from experience a little bit, but at some time or another I think you would have to come to a decision as to what percentage of the total cost of the total care given would be paid for by the subscribers and how much you would have to ask the Federal funds for.

Mr. CARLTON. Yes; that is true, sir.

There are, however, the natural limitations again that come in from the fact that the States have to put up, on the average, nearly 50 percent of this public assistance. As was brought out earlier, the States are essentially in control of this program.

Senator PEPPER. You do make the new contribution of the payment for the service obtained being upon the basis of the income.

Go right ahead.

Mr. CARLTON. The next point I would like to make, sir, is related to the question of public assistance in the purchase of health services. It seems to me that we have allowed ourselves to get so far behind in our medical resources that we cannot afford to jump right in and make up the deficiency overnight. I certainly agree with the principal on which your bill is based as expressed in Mr. Ewing's report to the President of last fall, to the effect: In order to recover the ground we have lost over many years, it is necessary to increase the effective demand for health services.

Senator DONNELL. What ground do you mean that we have lost over these years, in what respect?

Mr. CARLTON. That is the ground we have lost in the relative ability to provide adequate services to everyone, sir.

Senator DONNELL. Mr. Carlton, you think we have lost ground along that line?

Mr. CARLTON. It seems to me it is pretty clear we have lost ground, sir.

Senator FLANDERS. Mr. Chairman, I wonder if we have not lost it, in view of the greater knowledge and the greater effectiveness of medical care which exceeds the personnel and the institutions for giving it. That, it seems to me, is the reason that we have lost ground. It is due to the expansion of medical science which expanded way beyond the facilities and the personnel. Is that a fair statement?

Mr. CARLTON. It is.

Senator DONNELL. I would like the record to show there is one member of the committee who does not concede we have lost ground. I think the testimony from the medical profession indicates a great gain, and the fact that health in this country is better than any country in the world, unless possibly one or two very small countries. I think the efficiency of the medical profession in this country stands unchallenged. And this talk about having lost ground, I think, requires a great deal of detailed explanation in order to be at all convincing.

I do not mean that offensively at all, but I think it is very important that if Mr. Carlton considers we have lost ground, or Senator Flanders does, the committee have the benefit in considerable detail of just what they mean so that our committee may study those points.

Mr. CARLTON. If I may, sir, I would like to call your attention to the findings of the Committee on the Costs of Medical Care, the Chairman of which was the late Dr. Ray Lyman Wilbur nearly 20 years ago.

Senator DONNELL. Do you recall what the date was?

Mr. CARLTON. 1932.

Senator DONNELL. Seventeen years ago?

Mr. CARLTON. Yes.

Senator DONNELL. I am talking about recent years, in the last 10 years, we will say, as to whether or not we have lost ground. I thought you were referring to the loss of ground in the last 5 years. Did you not say that?

Mr. CARLTON. No; I did not.

Senator DONNELL. Perhaps I misunderstood you.

Mr. CARLTON. I meant to say the last many years.

Senator DONNELL. Do you think we have been losing ground since 1932?

Mr. CARLTON. I do not think there is much doubt about that, sir.

Senator DONNELL. What have we lost ground in in the last 17 years?

Mr. CARLTON. We fell badly behind during the depression and then during the war again.

Senator DONNELL. In what?

Mr. CARLTON. In the construction of new hospitals.

Senator DONNELL. We have the Hill-Burton construction bill, have we not?

Mr. CARLTON. That is right, and it is just beginning to make a dent.

Senator DONNELL. Has there been any decline in medical skill? Has there been any decline in national health? Has there been any decline in the ability of the medical profession to take care of the medical problems during the past 17 years in our Nation?

Mr. CARLTON. I am told, sir, by physicians whose opinion I deeply respect that the effect of the war in particular has been very serious on the quality of doctors being turned out by our medical schools. It was inevitable that it should be so because they were unable to complete their full course. There was a great acceleration in the training of the physicians, and that was a period of 5 years.

Now that kind of thing does not show up for a while, sir.

Senator DONNELL. May I interrupt you to ask you there, Mr. Carlton, was there not some counterbalancing value that was derived by the medical profession in the war from the vast clinical experience under emergency conditions that has been very helpful to the medical profession instead of harmful? Is that not true?

Mr. CARLTON. My impression, sir, that those doctors feel the experience that on the average physicians received in the armed services was a good deal less valuable than the experiences they would have received at home looking after the civilian population.

Senator DONNELL. Do you know what the relative infant mortality is today as compared to 15 years ago in this country, Mr. Carlton?

Mr. CARLTON. Yes, sir.

Senator DONNELL. What is it, how does it compare?

Mr. CARLTON. Three times better, as I remember it.

Senator DONNELL. Three times better today than 15 years ago?

Mr. CARLTON. That is right.

Senator DONNELL. What about the general mortality of the adults? What are the figures of today as compared to 15 years ago in the United States?

Mr. CARLTON. There is no question about it, on the basis of, let's call them the absolute figures, we are a healthier and an aging population.

Senator DONNELL. That is to say we live longer?

Mr. CARLTON. That is right, sir.

Senator DONNELL. We live longer today than we did 15 or 25 years ago on the average. That is true in this country—I am talking about the United States—is it not?

Mr. CARLTON. But the question is, perhaps, are we not living on our fat? Are we not the beneficiaries of the great development of medicine that took place between, roughly, 1910 and 1930?

Senator DONNELL. Do you think there has been any decrease in the developement of medical science relatively between 1930 and 1949? In other words, do you think medical science has gone back in its knowledge of the ability to handle disease problems between 1930 and 1949 in the United States of America?

Mr. CARLTON. They have not gone back, sir. The question is: Is the rate of accretion of medical knowledge continuing at the same pace as it did prior to 1930?

Senator DONNELL. And what is your judgment as to the relative accretion, the pace of accretion between 1930 and 1949 as compared with the period from 1911 to 1930?

Mr. CARLTON. Well, I take here, as I say again, the judgment of these physicians whom I deeply respect. In their opinion we are making less progress.

Senator MURRAY. Might I make an observation there, Senator?

Senator DONNELL. Yes, sir.

Senator MURRAY. When the deans of the medical schools were here the other day they stated they needed Federal aid to improve the quality of teaching in their schools, and said that the quality has gone down and is getting worse.

Senator DONNELL. The quality of what has gone down?

Senator MURRAY. The quality of teaching and the quality of graduates that are being turned out from the medical schools, and that we have to provide more funds to enable them to put in teachers that would improve those conditions.

Senator DONNELL. Has there been any showing, may I ask the Senator, in the evidence, according to his opinion, that there has been any decrease in general health conditions in the United States during the last 15 years?

Senator MURRAY. You mean on the part of the deans?

Senator DONNELL. On the part of the public. Has there been any decrease in the general physical conditions of the people of the United States in the last 15 years according to the evidence?

Senator MURRAY. I do not know of any evidence of that kind.

Senator DONNELL. Might I ask, if Mr. Carlton would not take offense, but he is testifying on very important matters, and may I ask him a little about his own background? You will not take any offense, Mr. Carlton?

Mr. CARLTON. I would love to.

Senator DONNELL. Would you mind telling us first where you live?

Senator FLANDERS. I would suggest that he read the first page of his statement.

Senator DONNELL. Of what?

Senator FLANDERS. Of his written statement.

Senator DONNELL. I am sorry I did not know he had a statement. I do not have a copy of it here.

Mr. CARLTON. Perhaps it would save the time of the committee to read this.

Senator DONNELL. I would like to know exactly what your background is, if you do not mind.

Senator PEPPER. Suppose you read the part responsive immediately to the Senator's question, Mr. Carlton.

Mr. CARLTON. All right, sir.

I am a medical care consultant and my office is at 70 Wall Street, New York, N. Y.

I entered the medical care field in 1938 as the volunteer manager of what was then known as the Cooperative Health Association in New York City. Two months later, on April 1, the association got into operation, providing the general medical services of six participating physicians to 10 families on a prepayment basis. The organization is now a New York membership—nonprofit—corporation, Group Health Insurance, Inc. Under several types of prepayment contracts, it covers more than 35,000 persons and has 3,200 participating physicians. I remained as its executive officer until 1945 when I became chairman of the board and treasurer, which positions I now hold, and have since devoted most of my time to consultation work.

Senator DONNELL. Might I interrupt you there to ask, Mr. Carlton, at that point, are you a physician?

Mr. CARLTON. I am not a physician, sir.

Senator DONNELL. Would you mind telling us when and where you were born and what your preliminary education is?

Mr. CARLTON. Surely. I was born by chance in London, England, of American parents in 1907.

Senator PEPPER. Did you feel that your birth there gave you a predilection toward socialized medicine?

Excuse me, Senator Donnell, I did not mean to be discourteous.

Senator DONNELL. How long did you live in England?

Mr. CARLTON. I think we came back here when I was 2½.

Senator DONNELL. You have not lived there since?

Mr. CARLTON. No, I have been back there once.

Senator DONNELL. What is your schooling, if you please?

Mr. CARLTON. I went to schools in New York City, and to Choate School at Wallingford, Conn., and then to Harvard University, Harvard College, where I graduated in 1929.

Senator DONNELL. With what degree, if you please?

Mr. CARLTON. With a bachelor of arts degree.

Senator DONNELL. May I ask in what you specialized in your collegiate course culminating in the degree?

Mr. CARLTON. I specialized in what was known as the field of history and literature.

Senator DONNELL. History and literature?

Mr. CARLTON. Yes. Then I went on to do 2 years of graduate work, a small part of it at Harvard and the rest at Columbia.

Senator DONNELL. What was your subject?

Mr. CARLTON. In economics and business administration.

Senator DONNELL. Economics and business administration?

Mr. CARLTON. Yes.

Senator DONNELL. Did you study in the course of either of those courses anything with respect to compulsory health insurance, of the experience of other nations with compulsory health insurance?

Mr. CARLTON. No, sir; I did not.

Senator DONNELL. Now you took that graduate work for 2 years. That takes you up to 1931?

Mr. CARLTON. I actually had a winter abroad before entering Columbia.

Senator DONNELL. That would bring you up to 1932 then?

Mr. CARLTON. That is right.

Senator DONNELL. When you were abroad where were you located, and what were you doing, please?

Mr. CARLTON. My field in college was the Italian Renaissannce history and literature of that period, and I was able to spend a winter in Italy seeing what I had been writing and reading about.

Senator DONNELL. That is along literary and artistic lines, is that right?

Mr. CARLTON. That is right.

Senator DONNELL. And you were studying along those lines rather than along the lines of medical subjects? You were not studying along medical lines?

Mr. CARLTON. That is right. I did not go into the medical field, as I have said, until 1938.

Senator DONNELL. Would you mind telling us between 1932 and 1938 what was your experience and type of work?

Mr. CARLTON. In 1932 I joined as a volunteer the staff of an organization called the Emergency Exchange Association.

Senator DONNELL. What was that?

Mr. CARLTON. Which operated in New York, and its purpose was to assist unemployed people to set up voluntary self-help associations and exchanges to exchange their labor for surplus goods.

Senator DONNELL. That had nothing to do with the medical problem again?

Mr. CARLTON. Nothing to do with the medical problem, no.

Senator DONNELL. And you were with it from 1932 to 1938?

Mr. CARLTON. No; I was with it 1 year, and then I was employed by the Federal Emergency Relief Administration in the division of the Bureau of Self-Help Cooperatives, and I was sent out to California in 1934 where I became the director of their self-help division and remained there until 1936.

Senator DONNELL. That was the Federal Emergency Relief Administration?

Mr. CARLTON. That is right.

Senator DONNELL. That was a federally operated organization?

Mr. CARLTON. Yes, sir.

Senator DONNELL. Operated out of Washington with branches throughout the country, is that right?

Mr. CARLTON. I worked first for the Federal Administration, and then I was employed by the State of California in their State relief administration.

Senator DONNELL. How long were you employed by the Federal Administration in this capacity?

Mr. CARLTON. I was employed for about 8 months, as I recall.

Senator DONNELL. What was the general nature of your duties while employed by the Federal Administration?

Mr. CARLTON. I was a field man in that work of aiding the self-help cooperatives under the Wagner Relief Act.

Senator DONNELL. Did that have anything to do with the study of compulsory health insurance?

Mr. CARLTON. No, sir; it certainly did not.

Senator DONNELL. And then you went with the State of California in what year?

Mr. CARLTON. In 1934.

Senator DONNELL. What was your duty with the State of California from 1934 on, and for how long did that duty continue?

Mr. CARLTON. I was director of the division of self-help cooperative service of the State relief administration.

Senator DONNELL. For how long?

Mr. CARLTON. I remained in that position until March of 1936 when I resigned.

Senator DONNELL. And your duties for the State of California had nothing to do with the study of compulsory health insurance and allied subjects?

Mr. CARLTON. Not a thing, sir.

Senator DONNELL. Am I correct in that?

Mr. CARLTON. That is correct.

Senator DONNELL. Beginning with March of 1936 when you resigned in California, what did you then do until 1938?

Mr. CARLTON. My wife and I then spent a year in Europe and England studying consumer cooperatives and cooperatives of all types.

Senator DONNELL. Did you make any study there as to any medical problems in England during that period?

Mr. CARLTON. No, sir, although that was my first acquaintance with the problem of medical care. And we were particularly interested in the medical cooperatives which were operating at that time in Yugoslavia. That was pre-Tito.

Senator MURRAY. We will take a few minutes recess to go to the floor and be right back.

(A short recess was taken.)

Senator MURRAY. We will resume the hearing. Proceed, Senator Donnell.

Senator DONNELL. Mr. Carlton, you were referring to your experience in England in 1936 to 1938.

Mr. CARLTON. From May 1936 until March of 1937.

Senator DONNELL. 1937. I misunderstood you.

Mr. CARLTON. And only part of that time in Britain.

Senator DONNELL. Yes, sir.

Now, during that period did you make any special study of the health problems and practices and the plan that was then in operation in England with respect to handling health matters?

Mr. CARLTON. I did not make a special study, sir, but it happens that my wife's family is Scottish and two of her cousins are physicians. I heard a great deal about their panel practice at that time which is, as you know, or was restricted to general practitioner care.

Senator DONNELL. What did you hear about the experience in the panel practice generally speaking? Was it considered to be successful or did it have some draw-backs?

Mr. CARLTON. Well, the opinion of these two physicians actually was split. One of them thought that it contributed to the deterioration of medicine. He practiced in the Midlands in England.

The other man practiced in a small town, Inverness, in Scotland, and in his opinion the system saved medical care for large sections of the British people.

So I imagine that medical opinion there is as diverse as medical opinion here.

Senator DONNELL. You did not make any special scientific study of the question yourself, Mr. Carlton?

Mr. CARLTON. No; I did not, sir.

Senator DONNELL. Now, from 1937 until your entry into the medical-care field what did you do?

Mr. CARLTON. After writing up some of our observations on the European and British cooperatives which took the summer and fall of 1937, I found this organization which I have referred to here in my statement, then known as the Cooperative Health Association. And they were in need of personnel; had no money to pay for it; and I was able, thanks to my family, to be able to give my services at that time. And I was glad to do so.

If I may read from this statement further?

Senator DONNELL. Certainly.

Mr. CARLTON. I entered the medical-care field because it seemed clear that our system of distributing health services had lagged far behind the development of the medical arts and sciences. The organizers of the Cooperative Health Association of New York were of like mind. Dr. Roberts loaned us a room in his office, we rented a typewriter, bought a second-hand filing cabinet, and started to work. As the organization's entire staff during the early months, and then as the responsible executive with an ever-tight budget, I gained experience in literally every function involved in organizing and operating a health-insurance plan, including the formulation of coverages, figuring costs and premium rates, drafting contracts, collecting premiums, and paying claims, promoting and selling the plan, negotiating with medical societies, and working with doctors in the administration of the medical services.

May I add that ours was the first prepayment plan to be approved by the New York County Medical Society.

Through my association with Dr. Roberts I was able to study many medical practice groups and later participated in the administration of a group for some months.

My knowledge of the field of medical care is, therefore, that of a practitioner, not of a theorist.

Senator DONNELL. Might I ask you whether or not since you entered this field you have had occasion to study the experience that has prevailed in England during the last year or so?

Mr. CARLTON. I have read the reports, sir.

Senator DONNELL. Yes, sir.

Mr. CARLTON. But I think it is fair to say that in the first year of a very large program of that kind, it is not significant, particularly significant, what their opinions and apparent experiences have been. These things take a long time to shake down.

Senator DONNELL. Have you read the article that recently appeared in the Saturday Evening Post by a Mr. Spencer on the recent experience in England?

Mr. CARLTON. Yes; I did.

Senator DONNELL. Are you willing to state generally, without going into detail, unless you desire to do so, whether you are inclined to think that his statement of facts is substantially correct as to the actual experience in England that has prevailed since the beginning of the present system?

Mr. CARLTON. I cannot really answer that, sir. I think that it is going to take a great deal longer time to tell really how they will come out. In general it has seemed to me that they could have expected a very high utilization of services during the first years of their program. And since they are relatively shorter of physicians and facilities than we, I should expect that we would experience an overloading of their personnel and facilities. That is the technical reason that I am not in favor personally of a compulsory program in their country.

Senator DONNELL. That is what I was coming to next.

Mr. CARLTON. Yes, sir.

Senator DONNELL. They have, even whether it be somewhat mitigated or entirely mitigated because it is the opening of their experience, actually experienced an overloading to which you refer. That is correct, is it not?

Mr. CARLTON. So far as I know nobody disagrees with that. The disagreement comes in interpreting or evaluating that overloading in terms of the effectiveness or lack of effectiveness of the medical care.

Senator DONNELL. Now, would you mind stating your reasons for not being in favor of a compulsory Federal health insurance program? That is if I am correctly quoting you as being not in favor of such a program.

Mr. CARLTON. As a technician, sir, it seems to me that a compulsory national scheme, even limited to hospitalization, would throw an immediate burden on our facilities and personnel that they are not equipped to bear.

Medical care is not something that you can put in a package and say, "Here it is; this is it."

It is an expandible or contractable commodity, and it is the universal experience that when the economic barrier is removed between the patient and the physician, there is an increase in the utilization of the physician's services. And the same thing applies to hospitals and so forth.

Now I think, sir, that all of us, certainly as indicated in the bill of which you are a sponsor, want to see that happen. We think that all of us, almost without exception, ought to make more use of physicians and health services generally than we have been accustomed to in the past, especially in view of the greater knowledge that we have today than we had many years ago.

The problem, it seems to me, is, as I started to say before, one of timing: How to increase the effective demand so as to bring it up close to the point at which it matches need for medical services—because those two things have been very far apart here—but to bring it up at a rate that will not overload what we now possess.

And to my way of thinking S. 1970 provides a method for creating what is in effect a potential effective demand which will bring out public and private funds to increase our facilities both for giving care and for training people, and also encouraging young people to go into the health profession.

Senator PEPPER. If the Senator would not object, at that point, rather than waiting until you are finished, I would like to ask a few questions.

Senator DONNELL. Certainly.

Senator PEPPER. Mr. Carlton, you recognize, however, do you not, that the national health insurance bill does not make any false promises to the people, it simply says it is going to provide the services that are available to the extent it is possible; and that it contemplates that the tax should start off at one-half of 1 percent and not 1½ percent; and that there be a necessity of determining on the part of the policy people at the top as to what services could be given?

That is the first thing.

In the second place, is it not true, however, that if we had national health insurance in effect and more people could get to use hospitals because we had hospital coverage it would make possible a more efficient use of the doctors and the personnel we do have because more people could be treated in hospitals, and doctors would have to spend less time running around over town and country to find their patients than is now true? In other words, would we not get a more efficient use and a fuller use of the facilities and the personnel we now have than under the voluntary system?

Mr. CARLTON. I do not think so, sir, for the reason that I do not believe that you will find we have sufficient facilities to bring all those patients into the hospital. I grant you that, as Dr. Garfield found out in the Permanente Foundation in California, it was more efficient to send an ambulance to the patient's home and bring him to the hospital and give care in the hospital than to send a doctor and, perhaps, a nurse out to the home. But in order to do that we would have to vastly increase our facilities.

Senator PEPPER. By the voluntary system you are not going to get complete coverage because you know all the folks are not going to join up in the voluntary system, and you know it is going to be between them and the facilities that we do have that we do have that financial barrier of which you spoke just a moment ago.

Mr. CARLTON. I am not prepared to say that I think that not all of the folks will join the voluntary plan. Literally that is correct, but the proportion of people who will not avail themselves of this opportunity, I believe, in the course of not many years will be very small.

Senator PEPPER. I did not want to interrupt the Senator's examination, but one last question at this point. What advantage does your plan offer to the potential subscriber not now offered by the Blue Cross and Blue Shield, and like the California physicians' plan, and so on, to make it more inviting?

Mr. CARLTON. A cost that is commensurate with his means. That is true of the lower half of the income group.

Senator PEPPER. The reason I asked that question is because the voluntary people who come in here and testify would have the casual listener believe that they give coverage even cheaper than the national health insurance plan proposes, which is only 1.5 percent direct tax on the subscriber. So I suppose your answer is that they cannot possibly for a lesser fee than you would charge give the same services that you would give?

Mr. CARLTON. I am very much surprised to hear that any responsible person from voluntary plans would claim that they could give the range of services specified in your bill.

Senator PEPPER. Or contemplated in the complete services in your bill.

Mr. CARLTON. For less than 3 percent. As a matter of fact, as we have indicated, we do not think that it can be done for 3 percent.

Senator PEPPER. You think even 3 percent—complete coverage leaving out dental as you propose to leave it out?

Mr. CARLTON. That is right, special duty nursing, drugs, medicines.

Senator PEPPER. Leaving all that out, it is your experience from your study of the subject that it would cost at least 3 percent of the pay rolls up to $5,000 of people covered and would require an additional Federal aid?

Mr. CARLTON. That is true. In other words, in my judgment—this I cannot certainly support as an actuary would support a statement—but in my judgment it will cost upwards of 4 percent of adjusted gross personal income up to $5,000 in order to provide that range of services.

Senator PEPPER. The national health plan, I suppose, comes out at about the same point by contemplating 3 percent to be derived from tax on the employee and comparable tax on the employer, and possibly 1 percent from the Federal Treasury.

Mr. CARLTON. Although the use of that 1 percent, as I recall it, is limited to certain additional services, is it not?

Senator PEPPER. Yes, that is true.

Excuse me, Senator Donnell.

Senator DONNELL. That is perfectly all right.

Mr. Carlton, I do not know what the general public opinion would be, but I assume if this legislation, the bill providing for the compulsory national health insurance, should pass, the public would be expecting some reasonably satisfactory results from it within a few years, we will say, 3 or 4 or 5 years.

I notice in that connection with much interest this sentence which is in the mimeographed statement to be given by yourself, and I ask you whether or not this does represent your considered opinion. You say——

Senator MURRAY. Where is that?

Senator DONNELL. Page 7.

You say—

> In our opinion, the enactment of compulsory health insurance, under the best conditions conceivably obtainable within the next 15 years, would overburden health personnel and facilities to the point where the quality of health services would be seriously depreciated.

Is that your considered opinion after studying it, Mr. Carlton?

Mr. CARLTON. Yes, it is.

Senator DONNELL. Mr. Carlton, in regard to the subject matter of Federal operation as distinguished from local operation, the plan that you gentlemen have developed and presented in S. 1970 proceeds in large part along the line of local administration, does it not?

Mr. CARLTON. Yes, sir; it does.

Senator DONNELL. And it does not have within it any such provision as that contained in S. 1679 by which there is created a national health insurance board, and that all functions of that board shall be administered under the direction and supervision of one Federal official, namely, the Federal Security Administrator, does it?

Mr. CARLTON. No, sir. The effort in S. 1970 is to decentralize responsibility and administration as far as possible.

Senator DONNELL. And do you regard it as desirable to decentralize it rather than to invest the ultimate functions of control in one Federal official, namely, the Federal Security Administrator?

Mr. CARLTON. Yes, sir.

From the technical point of view, I can only repeat what one of the bill's sponsors said earlier. I think it was Mr. Herter who said that there is very great variation over the country in our health resources, and in the conditions surrounding the rendition of health care. And it, therefore, has long seemed to me very important that a program of public assistance in this field should be determined at the local level. By "local" I mean a natural medical service area, not every village and township, but the concept of the health region which first, I think, appeared in the Hill bill and which we adopted in S. 1970.

It seems to me that a set-up of this kind would assure reflection of local needs, supplies, resources, and would stimulate community interest in developing better facilities and personnel, and they would take more interest in the problem of personal medical care.

Senator DONNELL. Without in any sense asking your ultimate opinion of S. 1581, that is the Taft et al. bill, am I correct in assuming that you favor the general line of approach of that bill to this extent at any rate, that it does not operate a federally controlled compulsory insurance system but makes grants-in-aid to the separate States under which they may operate in the light of local conditions? Do you generally favor that approach?

Mr. CARLTON. Within those stringently stated limits, I do.

Senator DONNELL. I am not asking you to commit yourself on the bill in its entirety. I wanted to get your judgment as to that particular portion of that approach of that bill, whether you favor that general attitude.

Mr. CARLTON. It seems to be very sound.

Senator DONNELL. Senator Flanders, if I might just ask you a question, with your good nature and your good humor.

You mentioned a while ago that—it is a sentence aside from context which might be misunderstood and I want to be sure I understand you. Some question was asked as to whether or not the bill you favor, S. 1970, is a compulsory bill, and I think you said, "It is a voluntary compulsory bill."

Senator FLANDERS. I said a voluntary bill with compulsory support.

Senator DONNELL. I take it you are not in favor, Senator Flanders, of a compulsory Federal insurance system. Am I correct in that?

Senator FLANDERS. That is true; yes, sir.

Senator DONNELL. Thank you very much.

Senator PEPPER. Mr. Carlton, I observe on page 2 of S. 1970, part B—Administration, Administration by Surgeon General.

> SEC. 711 (a) The Surgeon General is authorized to make administrative regulations and perform such other functions as he finds necessary to carry out the provisions of this title. Any such regulations shall be subject to the approval of the Administrator.

That is about as broad an authority as is given under the national health insurance bill?

Mr. CARLTON. If I may suggest, sir, I think it should be read in the context of the entire bill, however.

Senator DONNELL. What particular portion of the bill are you reading?

Senator PEPPER. Page 2, part B, section 711.

Then:

> In administering the provisions of this title, the Surgeon General, with the approval of the Administrator, is authorized to utilize the services and facilities of any executive department in accordance with an agreement with the head thereof.

And so on.

And then:

> In administering the provisions of this title, the Surgean General shall cooperate with and render advise and assistance to States and appropriate public authorities therein in formulating and operating State plans under this title.
>
> In administering this title the Surgeon General shall consult with a Federal Health Council consisting of the Surgeon General, who shall serve as chairman ex officio, and 10 members appointed by the Administrator.

Senator DONNELL. Would the Senator mind my interpolating at that point?

Senator PEPPER. Certainly not.

Senator DONNELL. Is it not true, even though the Surgeon General is authorized to make these administrative regulations under this bill, his authority is very distinctly limited later in the bill to seeing that the State plans are carried out, and is not at all analogous to the power of the Federal Security Administrator under the terms of S. 1679? Am I not correct in that?

Mr. CARLTON. Yes, sir; you are.

Senator PEPPER. Mr. Carlton, is this a case where Federal funds so far as I know for the first time are to be dispensed without the Federal Government laying down any standards or conditions for exercise or use?

Mr. CARLTON. I would not say so, sir.

Senator PEPPER. Then the Federal Government does reserve the right under your bill to lay down standards and conditions for the receipt of these funds?

Mr. CARLTON. The conditions and the standards, sir, are, as far as we could do so, stated in the bill. And if I might refer to section 725——

Senator PEPPER. Where is that?

Mr. CARLTON. Section 725 on page 24 of the bill dealing with payments to States.

Senator PEPPER. I notice you have there:

> From the sums appropriated pursuant to section 722 for any fiscal year, the Surgeon General shall pay to each State which has an approved State plan—

Say you contemplate that the States shall submit a plan and the Federal Government approve. Is not that the way it is in the national health insurance?

Mr. CARLTON. No, sir, because there is, if I can find it, a clause here which states——

Senator DONNELL. Which bill are you quoting?

Mr. CARLTON. S. 1970, sir. [Reading:]

> The plan shall be approved by the Surgeon General upon the certification by the Governor that the requirements of the act have been complied with.

Senator PEPPER. What are the requirements of the act?

Mr. CARLTON. They are set down here, sir, largely in sections 723 and 724 with respect to aid to the voluntary prepayment plans. Beyond that——

Senator PEPPER. I just notice, my eye happened to fall upon the following on page 21 of 1970:

> shall provide that the health region authorities and the State health council shall make reports to the Surgeon General at such times, and containing such data, as the Surgeon General, with the advice of the Federal Health Council, may by regulations prescribe;
>
> shall make provision, in laws enacted by the State legislature, authorizing any group of persons in good faith proposing to establish a prepayment health service plan to incorporate for such purpose as a membership or cooperative corporation; and shall, by changes in the State laws regarding incorporation and supervision of prepayment health service plans that are in operation in the State when this title becomes effective, or by such other means as may be necessary or appropriate, permit such plans to promptly qualify for becoming cooperating prepayment health service plans under this title.

And on page 20:

> shall provide for the supervision of the operations of cooperating prepayment health service plans by the State agency designated to administer the State plan.

There is certainly nothing improper. You will remember this is not the regulation of things that are provided for by funds paid by the people which the Federal Government requires them to pay. You are making an outright Federal subsidy—a grant of Federal funds—and I do not suppose you intend to have no strings upon those funds so you cannot have some general standards set for those who use them.

Mr. CARLTON. The financial standards are provided in section 723 (1), in the shape of what we have been calling the yardstick coverage which is to be used in determining a cost norm, and to that yardstick coverage is applied this 3 percent of the subscribers' adjusted gross income.

Senator PEPPER. May I direct your attention to page 130 of our bill, the National Health Insurance Act. It provides in section 741 the following:

> It is the intent of Congress that the benefits provided under this title be administered wherever possible by the several States, in accordance with plans of operations submitted and approved as provided in this part, and in each State insofar as feasible by the same State agency which administers or supervises the administration of the State's general public-health and maternal and child-health programs.

Now, what authority and power under the National Health Insurance Act is conferred upon Federal authorities which is not conferred upon them by the Flanders bill?

Mr. CARLTON. There seems to be a great many of them.

The final determination of what services may be provided in any area under S. 1679 is fixed, as I understand it, by the Federal Board. That is due reflection of the fact that the money is duly Federal money. The money comes into the possession of the Federal Government.

Senator PEPPER. I understand under the National Health Insurance Act that there would be a local council; that it be either an executive with an advisory council or an advisory council; that it would determine these matters in the local community; come up through the State; all be provided for in the plans; and then the plans would be approved generally by Washington.

Mr. CARLTON. There is complete discretion as to the approval of those plans by the Federal Board. Is that not correct?

Senator PEPPER. I beg your pardon?

Mr. CARLTON. There is complete discretion vested in the Federal Board as to the approval of those proposals.

Senator PEPPER. You mean of the plans?

Mr. CARLTON. Yes, sir.

Senator PEPPER. That is true in your case; your plans have to be approved by the Surgeon General, do they not?

Senator FLANDERS. Mr. Chairman, if you will excuse me, the plan, as I see it, is detailed in the bill (S. 1790) and the Surgeon General's office is to make sure that the requirements of the bill have been met. Now, they can be met by a wide variety of cooperative groups and others working in a wide variety of ways so long as they come within these specifications, and it seems to me in this bill the Surgeon General is required to certify that they come within the framework of the bill rather than to exercise any arbitrary judgment whatsoever.

Senator PEPPER. Is not that all the national board contemplates doing under the National Health Insurance Act? To see that the plans are observed, but the national health-insurance bill provides you cannot change the plans for a year; that is, you cannot require any change for a year. In other words, what you contemplate is the same thing we contemplate.

What does the national health-insurance bill provide on that subject, Mr. Reidy?

Senator FLANDERS. I might say one notable difference is that a State can refuse to come in at all under this and cannot under your bill.

Senator PEPPER. That is right. You have the voluntary plan of membership.

What do you have to say, Mr. Reidy, you have studied the subject?

Mr. REIDY. The national health-insurance bill carries a specific statement of policy under which the act must operate, a policy of decentralization in section 731, which states specifically:

> In order that personal health-service benefits may be made available promptly and in a manner best adapted to local practices, conditions and needs, responsibility for administration of the benefits provided under this title in the several local health-service areas shall be decentralized as fully as practicable to local administrative committees or local administrative officers, acting with the advice and assistance, as provided in this part, of local professional committees and, in the case of local administrative officers, the advice and assistance of local area committees. The health-service areas of a State shall be those so designated in the State plan of operations.

Senator PEPPER. Now what is the power under the act of Federal authority? Is the State plan required to be submitted by the State? Do they have to reject or approve the plan, to see whether it is in conformity with the purpose of the law?

Mr. REIDY. Yes.

Senator FLANDERS. I might say I welcome likenesses, so that any likenesses found between the two do not disturb me.

Senator PEPPER. That is the point I am bringing out. I was thinking probably the likeness was rather conspicuous, and that anybody who purported to use Federal money had to show some proper regard for the proper use of that Federal money. We agree upon that principle. If we do, there is no difference at all.

Senator DONNELL. Would the Senator yield for a question or two at this point? I think it would be of importance in clearing this up.

Senator PEPPER. I yield.

Senator DONNELL. As I understand the Flanders bill, there is every difference in the world between the extent of ultimate Federal control and that which is contained in S. 1679.

In the first place, as I understand it, in the Flanders bill, while I have not studied it except for a casual glance at it this morning, it is clear a State plan is to be submitteed and must comply with certain requirements of the Flanders bill; and the Surgeon General, having power to make regulations, if he finds the State agency is not complying substantially with provisions of the State plan, can shut off the payment of Federal funds. That is perfectly clear, but that is entirely different, as I see it, from S. 1679.

It has been referred to here by Mr. Reidy that under section 731 there is a declaration of policy here, and a declaration of what must be done, and he has read—what was that section number?

Mr. REIDY. Section 731, page 123.

Senator DONNELL. Yes, page 123.

Now he has read there about the fact—let me just read it here:

> In order that personal health-service benefits may be made available promptly and in a manner best adapted to local practices, conditions, and needs, responsibility for administration of the benefits provided under this title in the several local health-service areas shall be decentralized as fully as practicable to local

administrative committees or local administrative officers, acting with the advice and assistance, as provided—

and so forth.

But I call attention to the fact over on the botton of page 129 is this statement, beginning at line 20:

> In exercising their functions and discharging their responsibilities under this title—

and that is the local title in the compulsory health insurance—

> local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title, and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

But the regulations prescribed under this title, it is distinctly stated, are to be made by this National Health Insurance Board which is created on pages 136 and 137, for it says on page 138:

> The Board shall perform such functions as it finds necessary to carry out the provisions of this title, and shall make all regulations and standards specifically authorized to be made in this title, and such other regulations not inconsistent with this title as may be necessary.

So, Mr. Chairman, it seems to me perfectly clear, while under the Flanders bill, the Surgeon General certainly has a right to watch the operation of the plan and, if it does not tally up with the provisions of the bill, has the right to shut off the money, this Board under those regulations and also under the local regulations, it is true also these local committees must operate, but this Board is a national board which has power to make all regulations and standards authorized to be made, and those not inconsistent with the title.

And then, in addition to that, the functions of the Board, after all these great powers of administration are granted to it, are expressly stated on pages 137 and 138. [Reading:]

> All functions of the Board shall be administered by the Board under the direction and supervision of the Federal Security Administrator.

So we have on the one hand in the case of Senator Flanders' bill, as I understand it, a situation in which a State plan is prescribed, the definition given as to what it shall contain; the Surgeon General has power to make regulations and to refuse to give money if that State plan is not adhered to, but no general powers such as this Board has. But the Board has the power to make the regulations under which these local administrative committees, about which Mr. Reidy has read us this morning, must operate, and that National Board, in turn, is subject to the direction and supervision of one man, namely, the Federal Security Administrator.

Senator PEPPER. Senator, if you will allow me, I pointed out a minute ago that it said in the Flanders bill the Surgeon General has authority to make rules and regulations, and of course those beneficiaries of this Federal aid and State aid would have to observe these rules and regulations.

You were referring on page 129 to the language—

> In exercising their functions and discharging their responsibilities under this title local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title—

I do not see anything different between that and the Flanders bill.

> and of regulations prescribed thereunder, and of any regulations, standards, and procedures prescribed by the State agency.

Of course, they have to comply with the requirements of the State agency. But the language that you read is a part of section 735, "Methods of administration," and follows immediately section 734, the caption of which is "Local professional committees," and the immediate preceding title is "Local Area Committees, Section 733"; and the immediate preceding section 732 is "Local administrative committee or officer."

And then the part D under which the language you read on page 123 is headed "Part D—Local administration—Decentralization of administration," which appears in section 731, and so on.

So, it seems to me I do not know there is very much difference there.

Senator DONNELL. I would say, Mr. Chairman, certainly there are plenty of headings about centralization, local administration, local administrative committee or officer, local area committees. This word "local" is constantly before us in these headlines, but when you get down to the bottom of page 129 these local groups all operate not solely under the standards prescribed by the State agencies, but also—

> In exercising their functions and discharging their responsibilities under this title, local administrative officers and communities, local advisory committees, and local professional committees shall observe the provisions of this title and of regulations prescribed thereunder.

After which it refers to the regulations, standards, and procedures prescribed by the State agency under which, of course, they must also operate.

The point I make, there is a very clear distinction, I understand—and if I am wrong I would like to be corrected—because in the Flanders bill there is simply a description and definition of what the State plan must concern, and the Surgeon General has the right to determine if the plan is being carried out; and, if he finds it is not, he can shut off the money. He does not operate as an operating board or individual; he is simply there to see that it is carried out under the State plan. Whereas under S. 1679 the Board has the power of all these regulations and so forth I have referred to, and the Board itself, in turn, is subject to the supervision and direction—I believe that is the language of it—yes—the supervision and direction of the Federal Security Administrator.

Senator PEPPER. But the Federal Administrator is not the operating agency. Under the National Health Insurance Act the Federal Board is not the operating agency, and neither is the Surgeon General.

Senator FLANDERS. The spirit of S. 1790 is that initiative for the plans, operations, and so forth, come up from the local situation to be certified rather than authority, plans, administration, and so forth, coming from the top down. Distinctly, they come from the bottom up in the spirit of this S. 1790. At least that was the intention in drafting it.

Senator DONNELL. I might also mention provisions on pages 147 and 149 of the administration bill, S. 1679:

> The Board, after consultation with the Advisory Council, shall determine, as far in advance of the beginning of each fiscal year as possible, the sums which shall be available from the account for provision during the fiscal year of all

classes, and of each of the five classes, of personal health-service benefits specified in section 701 (a).

And on page 147:

> There is hereby created on the books of the Treasury of the United States a separate account to be known as the "Personal health-service account."

And:

> Funds in the account not required for current withdrawals shall be invested by the Secretary of the Treasury in the types of obligations which may be acquired by the Federal old-age and survivors insurance trust fund.

As I have pointed out, under section 772 (a) on page 149 it is this Board which determines, after consultation with the Advisory Council, which is also a Federal council, the sums which shall be available from the act for provision during the fiscal year for all these classes, and each of them.

I think that is very different than the functions, as I understand, of the Surgeon General under the Flanders bill.

Do you not consider those to be material and considerable differences between the two bills, Mr. Carlton?

Mr. CARLTON. They seem to me to be, sir.

Senator DONNELL. It has not been expressly mentioned, Mr. Chairman, but may I suggest in fairness to him the witness' statement in full be set out in the record. I move at the conclusion of his oral testimony it be set forth in full.

Senator MURRAY. It will be carried in full.

Does that conclude your statement, Mr. Carlton?

Mr. CARLTON. Yes, sir.

(The statement submitted by Mr. Carlton in full is as follows:)

STATEMENT BY WINSLOW CARLTON, MEDICAL-CARE CONSULTANT

My name is Winslow Carlton. I am a medical-care consultant and my office is at 70 Wall Street, New York, N. Y.

This winter I was invited to serve as medical-care consultant to a group of distinguished Republican Senators and Representatives who wished to give special attention to the health problem. I was glad to accept and to have had the opportunity of working with them on the bill which is now before the committee. Since I am appearing here today in the capacity of a technician, perhaps I should give a sketch of my experience.

I entered the medical-care field in 1938 as the volunteer manager of what was then known as the "Cooperative Health Association" in New York City. Two months later, on April 1, the association got into operation, providing the general medical services of 6 participating physicians to 10 families on a prepayment basis. The organization is now a New York membership (nonprofit) corporation, Group Health Insurance, Inc. Under several types of prepayment contracts, it covers more than 35,000 persons and has 3,200 participating physicians. I remained as its executive officer until 1945, when I became chairman of the board and treasurer, which positions I now hold, and have since devoted most of my time to consultation work.

I have served as medical-care consultant to the following organizations, among others: New York University College of Medicine; Long Island College of Medicine (in association with Dr. J. J. Wittmer, medical director of Consolidated Edison, of New York, and a trustee of Long Island College of Medicine); Group Health Association, St. Paul, Minn.; Insurance Fund of the New York Hotel Trades Council and Hotel Association (in association with the late Dr. Kingsley Roberts, director of medical administration service); and to a group of medical advisers formed by the late Mayor Fiorello H. LaGuardia. As a result of the last-named assignment, I became secretary of the organizing committee and first secretary of the board, and an incorporator, of the health-insurance plan of Greater New York.

During my 11 years in this field, I have also participated actively in a number of organizations concerned with the development of health insurance and methods of providing medical care. These include Medical Administration Service, Inc., which served, until Dr. Roberts' death a year and a half ago, as the national focal point for the development of group medical practice. I am an incorporator and director of the Cooperative Health Federation of America, successor organization to the Group Health Federation of America which I served in like capacities. I am chairman of the health services committee of Eastern Cooperatives, Inc., and a member of the American Public Health Association, medical-care section.

I am not a physician. I received a bachelor of arts degree from Harvard College in 1929 and then did 2 years of postgraduate work at Harvard and Columbia in economics and business administration. I entered the medical-care field because it seemed clear that our system of distributing health services had lagged far behind the development of the medical arts and sciences. The organizers of the Cooperative Health Association of New York were of like mind. Dr. Roberts loaned us a room in his office, we rented a typewriter, bought a second-hand filing cabinet and started to work. As the organization's entire staff during the early months and then as the responsible executive with an ever-tight budget, I gained experience in literally every function involved in organizing and operating a health-insurance plan, including the formulation of coverages, figuring costs and premium rates, drafting contracts, collecting premiums and paying claims, promoting and selling the plan, negotiating with medical societies and working with doctors in the administration of the medical services. Through my association with Dr. Roberts, I was able to study many medical-practice groups and later participated in the administration of a group for some months.

My knowledge of the field of medical care is, therefore, that of a practitioner, not of a theorist.

I should add that I also had 3 years' experience as a Government employee, first with the Federal Emergency Relief Administration in 1933–34, then with the California State Relief Administration as director of the division of self-help cooperatve service in 1934–36.

So much by way of biography. When I came to Washington in March, the first thing we did, as a group, was to study the major proposals which had been, or were shortly to be, placed before this session of Congress. The main conclusions we reached, after several weeks of analysis and discussion, are summarized in the form of a brief comparation of this bill with S. 1465, S. 1581, and S. 1679, which appears at the end of a statement issued by the sponsors at the time the bill was introduced.

"In principle this approach to health insurance is similar to that of the Hill bill, but with several important differences. One is that the Hill bill in effect requires those who need help in paying for voluntary prepayment plans to pass an individual 'means test', while this bill gives everyone the automatic right to join a prepayment plan at a charge that he can afford. On this point, the Taft bill is less explicit but just as clearly contemplates the use of a means test.

"Under the Hill bill public aid would go only to prepayment plans offering no more than in-hospital care and the out-patients services of hospitals and diagnostic centers. This bill leaves the scope of services for which public funds may be used solely to the discretion of the States and their health regions. From the beginning people in many communities will secure far broader benefits, such as home care and preventive services of doctors, where the community is equipped to supply them.

"Both the Hill and Taft bills fail to provide for the free organization of prepayment plans within the States. At present in 22 States the organizations of such plans is effectively restricted to medical societies. In contrast our bill provides positively for State enabling acts which would permit the free organization of prepayment plans.

"The Taft bill concentrates all attention on those unable to pay the whole cost of care and requires the States to develop programs that would assure such persons all needed services within a period of 5 years. This requirement, we feel, is totally unrealistic in the light of the proposed maximum appropriation of $300,000,000, which, added to State funds, would provide no more than $600,000,000 a year of public funds for this purpose. In our judgment it would take five times as much money and more than 10 years' time to reach the Taft bill's goal.

"On this score, the Thomas bill is equally unrealistic. Starting in July 1951, it would impose a pay-roll tax of 3 percent on the employed and an income tax of 2¼ percent on the self-employed, for which there would be given as broad a range of services as the Federal Government believed could be supplied in the various States. But while theoretically only services that could be provided would be promised, the payment of so substantial a tax would necessarily confer on the taxpayer a right to demand comprehensive care. This insistent demand would force a burden on hospitals, doctors and auxiliary personnel that they could not possibly carry. The result would be grossly inadequate service and an irresistible demand for direct Federal control. In contrast, this bill links the extension of prepaid services with the local capacity to supply service. There is no element in this bill that will force or encourage public authorities or prepayment plans to issue contracts that cannot in fact be fulfilled.

"The Hill, Taft and Thomas bills all provide for surveys or studies of various elements of the health field. This bill seeks to unite all these partial studies and many others into a single coordinated whole, looking toward the formulation of a national long-range program. There have been too many fragmentary studies and plans. It is time for the health problem to be treated as a single problem, one of the biggest and most basic problems the Nation faces today.

"The goal of this bill is the most efficient production and distribution of medical care for the benefit of all the American people. We propose means for moving immediately toward that part of the goal which is realizable with present resources and those that can be developed soon. The survey is intended to amend the means if necessary, to develop further means, to state the further goal of covering all the health needs of the American people, and to work out the means of achieving that ultimate goal."

The paragraphs quoted above make it clear, I think, why this group of Senators and Representatives decided to undertake the difficult task of drafting a new measure. They earnestly desired to find a course between the Scylla of compulsion and the Charybdis of the "means test." Broad social philosophy contributed to this desire, but an equally important consideration was technical—that is, what would be the effect of applying either of these devices to the Nation's health service system?

In our opinion, the enactment of compulsory health insurance, under the best conditions conceivably attainable within the next 15 years, would overburden health personnel and facilities to the point where the quality of health services would be seriously depreciated. As stated above, we believe that a program based on local, voluntary action will not have that result. People are seldom willing to pay for unavailable services.

The fact that we do not as a Nation have sufficient medical resources to supply full health care to everyone must be laid to years of underexpenditure for medical care. The condition was pointed out clearly by the committee on the costs of medical care, under the chairmanship of the late Dr. Ray Lyman Wilbur, nearly 20 years ago. Since then, depression and war have intensified the underlying shortages. Only the rapid growth of prepayment and insurance plans during the past 15 years has offered hope of fundamental improvement in the economics of medicine, since prepayment, or insurance, tends to increase expenditures by lifting the burden of cost from the backs of the sick and bringing it within the normal family budget.

Yet we all recognize that a very large proportion of American families cannot afford, even on a budgetable, prepayment basis, to bear the full cost of modern health services. The fact that Government assistance is necessary is reflected in all the bills now before the Congress. If such assistance is made available only upon application to a public agency to which proof of need must be submitted, the type of care paid for will inevitably be different from the care purchased by the rest of the community. "Special arrangements" would be set up—or continued—for the care of recipients of public aid, with a view to stretching the tax-raised dollar, just as the charity dollar is stretched in wards, dispensaries and out-patient departments. The technical quality of charity care is often good, but it is seldom personal in the sense that a consistent relationship is established between doctor and patient that permits the doctor to see the patient as a whole person. By and large, it seems accurate to say that such care is mechanical and impersonal, adequate for some types of treatment but poor in providing the positive qualities of full health service.

S. 1970 proposes a quite different method of getting needed public assistance to those who cannot afford to pay the full cost of care under prepayment plans. It would substitute for the flat-rate premium a subscription charge scaled to the subscriber's income. To the extent that the aggregate of these charges collected by a given nonprofit plan falls below the reasonable cost of providing services to its beneficiaries, Federal and State moneys would be supplied. In this way everyone is treated alike, irrespective of income; those whose means will not carry the full average cost of service will be eligible, as a matter of right for the same benefits as anyone else in return for contributing his share to the pool.

In a rough and only partially effective way, that is how medical care costs are borne today. The "sliding scale" of doctors' fees is traditional with the profession.

Once the simple principle of scaled-to-income charges for prepaid health services is accepted as reasonable and just, the immediate question arises, what proportion of income constitutes a fair charge for a specified range of services? The bill sets 3 percent for the quite comprehensive range of benefits detailed in section 723 (1) (pp. 15–16). These benefits were selected as the "yardstick" because they are measurable in terms of the need for medical services, sufficiently broad to embrace nearly any service that would be practicable under present conditions of supply, yet not so broad as to extend beyond the limits of practical experience. The volume and quality of that experience are daily increasing. That is not to say that there is yet sufficient experience to permit the formulation of a standard "Table of health service utilization" comparable to the life expectancy table—that will come only with the large-scale development of comprehensive prepayment plans. But calculations of probable cost for this extent of coverage need no longer be pure guesswork.

Three percent of the first $5,000 of the subscriber's adjusted gross income was selected as the percentage, as a compromise between the current level of expenditure for these services and the maximum amount that families of modest means might reasonably be expected to pay under existing patterns of family and individual spending. It is a pragmatic figure. If the percentage were placed too high, people would not subscribe; if too low, the voluntary character of the program would be vitiated.

The bill calls upon each health region authority to estimate the reasonable per capita cost of supplying these services in its region. This, it should be borne in mind, is in no respect different from the kind of estimate that every prepayment plan must make before it offers a contract to the public. It is expected that technical work in connection with drawing up this estimate will be done by the State agency to which the program's administration is assigned by State law. The chief function of a health region authority in this instance, as in most others, is to bring the grass-roots' judgment of its members to bear on such questions as the level of reasonable fees and charges within the region. In making this kind of determination, the authority will be aided by its technical committees representing the providers of the medical, hospital, nursing, and other services. Final decisions as to the reasonableness of the estimate arrived at by each health region authority is vested in the State health council.

May I here say that we are indebted to the authors of S. 1465 for the concept of these health region authorities. We believe that there is no better way to assure adequate reflection of local health needs and resources than by placing real responsibility in the hands of such boards.

The extent of supervision and control which the public bodies and agencies would exercise over the voluntary plans, under the proposed program, would, we think, not be substantially greater than that which is now exercised by State agencies (usually the insurance department) over existing voluntary plans. In most of the States, a very watchful eye is kept on these plans. They must, of course, submit contracts and premium schedules, before issuing them to the public, to the supervising agency for review as to financial soundness and fairness to the subscriber. Anyone who has operated a plan under a State insurance law will, I believe, agree that this bill is, if anything, moderate with respect to its requirements for public supervision.

The effort has been made throughout to set up formulas which could be objectively administered—as, for example, the "selection factors" which are intended to compensate plans for unbalanced risks, due to accepting individual applicants on a first-come, first-served basis or otherwise departing from the "preferred risk" policy of enrollment. Determination of these "selection factors" has been vested in the Federal agency for the reason that it is a purely technical matter which can best be worked out, and from time to time adjusted, on the basis of Nation-wide experience.

It is evident that the principle underlying the bill is freedom of enterprise. Within the limits imposed by a State's health resources and fiscal position, voluntary plans may offer any combination of benefits for which they think there is an effective demand. Then, if one plan is better managed than another and effects savings within the allowed cost of th ecoverage, it will obtain a competitive advantage by having additional benefits to offer for the same subscription charge. Although no profits may accrue to anyone, my experience is that the managers and trustees of voluntary plans respond with energy and ingenuity to competition.

Before closing, I should like to call your particular attention to section 724 (p. 23) which deals with areas of special need. These araes are defined in section 721 (j) (pp. 9–10) as regions within a health service district which have no more than eight physicians in active practice per 10,000 residents. The bill proposed that mixed Federal-State funds, over and above the assistance given to prepayment plans, be provided to underwrite, in effect, the operating expenses of coordinated health service systems in those areas. The participation of a 4-year medical school is called for in those programs in order to provide a vital ingredient that guarantees and premium payments do not supply, namely: an attractive professional environment for well-trained, conscientious doctors and other professional personnel. We already have a serious imbalance in the distribution of our health personnel; experience abroad indicates that a program which substantially increases the effective demand for medical services, nationally, accelerates the drift away from rural communities. Let us heed their experience and take steps early in any national program to reverse that trend.

Senator MURRAY. The committee will reserve the right to submit some questions in writing to the sponsors of this bill. Inasmuch as this is quite a comprehensive bill and it is the first opportunity we have had to look into it, I would like to reserve the right to submit a few questions to the sponsors of the bill so they may be answered in writing in case we find it necessary.

Senator DONNELL. I think that is very fine that should be done.

Senator MURRAY. That concludes the testimony now, and we have some other witnesses here, and we will resume at 2 o'clock.

Senator PEPPER. Before we recess, if I may, Mr. Chairman, I have a number of communications here, some of which are rather new. They keep sending me these various letters which I ask permission to insert in the record with instructions to the reporter that the name and the town of the writer of the letter not appear. If there is no objection to that, that is, or if there is, I will read them myself at the appropriate time. But I am perfectly willing to leave them on file. I would rather retain them for myself.

I have a number of letters here from people from my State, some from out-of-State, who have written me about going into doctors' offices and having these cards handed to them.

Here are some of the printed cards. Here are three, for example.

These were handed out to patients who went into doctors' offices.

They had some printed with my name on there. Evidently these cards were printed up. There are two from my State here.

Here is another one printed up to Hon. Harry S. Truman, White House, Washington, D. C.

Here is one printed "Hon. Claude Pepper, Senate Office Building, Washington, D. C.," and the rest of them with my name printed on.

Evidently they were printed and all are similar.

Here is one:

> DEAR SIR: It is my belief that American medicine and dentistry as practiced today have been leading factors in placing the health of the people of the United States—

the card reads—

> below that of any other great nation.

But the writer has inserted in ink instead of the words "above that of any other great nation," the words "below what it should be."

Then he allows the language to remain as it is:

> The advancements which have made this leadership possible could have resulted only from the strong desire for scientific improvement and the individual initiative which exists in systems of free enterprise.

Then the card says:

> For this reason I am opposed to any form of compulsory health insurance.

Then it says, "Your very truly" and has "signed" and "address" and "city and State."

This writer has stricken out the word "opposed" and inserted the word "favored." So it is "favored to any form," and he has stricken out the word "compulsory" and written in "equitable."

So it says:

> It is my belief that American medicine and dentistry as practiced today have been leading factors in placing the health of the people of the United States below what it should be.

Then he concludes:

> For this reason I am in favor to any form of equitable health insurance.

The person is from Daytona Beach, Fla. It gives the name of the party and the specific street address. That card is dated May 23 of this year.

Here is another one. This is a little different form, but it is printed "Hon. Claude Pepper, Senate Office Building, Washington, D. C.," and postmarked May 24, 1949.

The way the card reads:

> Dear Sir: As for myself and family, which consists of ---- votes—

I do not know just what the information about the number of votes in the family was intended to convey about the various plans, but—

> As for myself and family, which consists of ---- votes, we are unalterably opposed to compulsory health insurance or any other form of legislation which tends to regiment our population and socialize our Government.

And "Very truly yours," with a place for the signature and the address, and the city and State.

Here is the way the writer has altered it to read:

> As for myself and family, which consists of four votes, we are not opposed to compulsory health insurance or any other form of legislation which tends to help—h-e-l-p—our population and improve our Government.

Then is the name of the writer, the address, and the city and State.

Now, then, at the bottom, the writer has written the following:

> This card cost the AMA at least 1 cent of their millions they have to fight a good law and keep suffering humanity suffering for their selfish interests. Only the rich or near rich can afford doctors these days, even for their children.

Now here is another one that is also a printed card, dated May 12, postmarked, and this is from Florida, and this is the same form as the other. It is printed a little differently, so evidently the form is sent out and the local society or somebody must alter the exact type in the various communities. But it is the same language as the other one.

This writer says:

> As for myself and family, which consists of two votes, we are heartily in favor of compulsory health insurance—

with an exclamation mark. And then it is written down at the bottom, if I am not presumptuous in quoting it—

> We endorse your liberal record.

I guess they meant endorse my support of the national health insurance.

I have a number of letters, and a telegram from Jacksonville which says:

> Please, my dear Claude, uphold Mr. Truman on his health-insurance plan. We old folks, regardless of the AMA and their high-powered lobbyists, the bill should pass. Socialized medicine is a name only. It should be nationalized medicine, and God knows we need it now. Claude, please stay with the President on this bill.

And the name and signature is given.

And here is another one that is in a different form, another card. This one is imprinted "Hon. Harry S. Truman, White House, Washington, D. C.," and another one "Hon. Charles E. Bennett," one of the Congressmen from Florida.

And this fellow signs the card and gives his address, and the only alteration he makes, the card concludes—

> For this reason I am opposed to any form of compulsory health insurance.

He writes "not" down there at the bottom so it reads:

> I am not opposed to any form of compulsory health insurance.

And here is another one, also from Florida, which says:

> Your letter of May 4—

this is to one of the Congressmen—

> received, acknowledging receipt of my card sent to you in reference to compulsory health insurance.
>
> I wish to state this card was signed by me on what you might call pressure. At the time I signed this card my wife was in the hospital for an operation, and while at the doctor's office I was handed this card to sign; under the circumstances I felt that I was compelled to sign even though I am 100 percent for compulsory health insurance.
>
> It is my belief that thousands of other persons are handed these cards to sign under similar circumstances, and it is very unfair to all parties concerned.
>
> It is requested that this card signed by me be stricken from your records or returned to me.

And there are a good many letters in the same vein. I would like to insert, as I said, these communications without giving the name of the person because we do not want to embarrass them. If anybody wants to see the originals I will be very glad to show them. Otherwise I would read them myself into the record.

I merely want to call attention to what appears to be not only an admitted program under which $25 is levied from the medical association against the members which, as one of the witnesses testified, has already raised a million and a half dollars, and somebody else said, $2,000,000, but in addition to that there is a high-powered pressure campaign that somebody is paying for going on all over this country in the offices of the doctors and dentists and before the civic clubs and women's organizations. They are presented these resolutions. They have this literature left in front of their plates.

Now I do not know who is paying for that but I do not know of any comparable literature that is being sent out at public expense. And

I know those of us who are advocates of this measure have not got any money to do that kind of thing with. And I am of the opinion that, therefore, a lot of people are being told something other than the facts.

Here is another one from a man from Florida, and he says:

> The attached card ought to have no weight at all.
>
> They were shoveled out at a recent insurance State convention, and people were asked to get scillions of them signed and mailed.
>
> No discussion of the merits of the matter. And a total disregard of the differences between socialized medicine and public medicine. And yet people are in favor of public education. Are they opposed to public good health?
>
> Cordially yours.

And this gentleman is himself in the business of life insurance—"Life insurance—annuities—retirement incomes" in one of the cities of Florida. And he says this has been going on at the insurance conventions.

So, talk about propaganda. It looks like there is a great deal of, I will say, information, at least, instead of using the word "propaganda"; that there is a lot of information that reflects a particular point of view that is being disseminated over this country, and I just wonder how much it is all costing and who is paying the bill.

Thank you very much.

(The letters and data submitted by Senator Pepper are as follows:)

———, *June 10, 1949.*

Hon. CLAUDE PEPPER,
Senate Office Building, Washington, D. C.

DEAR CLAUDE: The membership of the ——— ——— Club round table has been reliably informed that the American Medical Association or one of its subordinate chapters is circulating among the people of ——— petitions for protest against enactment of the compulsory health-insurance bill. In all probability, the people among whom such petitions have been circulated, such as the cigarmakers in ——— ———, actually do not know the true purpose of the petition and it is the desire of the round table to begin a campaign to oppose these activities of the AMA.

The round table is also anxious to cooperate in every way with you in securing the enactment of this beneficial law and has requested me to write you as to what form of its efforts you wish to accomplish the desired results. If resolutions of the ——— ——— or of the round table will be helpful, if they can be immediately obtained and copies sent to you. We will be pleased to have you advise us as to how we can be of the most assistance in securing the passage of the act.

With kindest personal regards, I am,

Sincerely yours,

——— ———.

APRIL 26, 1949.

Senator CLAUDE PEPPER,
Congressman HARDIN PETERSON,
President HARRY TRUMAN.

GENTLEMEN: I was in a doctor's office a few days ago for treatment, I believe it was my first call at this doctor's office; I was immediately presented with cards to sign protesting against the health program; these cards were addressed to each of you. Naturally, I feared to antagonize the doctor and his nurse, so I signed them. Inquiry among my friends and associates discloses that they too have had the same experience, although they, like myself, are in favor of a health program.

Most of us, recognizing the fact that there is a shortage of nurses and office attendants, not to mention doctors and hospital rooms, are in favor only of free health care for all our natural-born citizens under 20 years of age.

Later on, we can take care of everyone from birth to death—but right now it seems impossible to begin with such a drastic change or undertaking; it would probably bog down, thereby defeating the entire idea for a long time.

Just look around at any public gathering and imagine what a change in the people there would be if all there had been given needed medical care from birth to their twentieth birthday. It takes training to accustom anyone to such a big step in progress as the health program is—and one reason that we should leave out the adults in the beginning of the program is that there are so many who would take the attitude "Oh, well, I'll indulge in anything I feel like and then go to the doctors' and get taken care of." Children would not take that attitude and by the time they too are grown they will have been trained in the idea that preventive measures are the basic or foundation habits that promote lifetime health.

All my children are more than 18 years of age, so this idea does not have its roots in selfishness. Everyone whom I have talked with agrees with this idea 100 percent.

Why not eliminate the charges hospitals make for nurses' training? Don't you think the trainees earn their tuition?

,————————, ————, *May 13, 1949.*

The Honorable Claude E. Pepper,
Committee on Foreign Relations, United States Senate,
Washington, D. C.

Dear Senator Pepper: Please accept my thanks for your letter of April 27 on the subject of "socialized medicine." Frankly, you have given me a lot to think about and after reading your message, I am inclined to agree with you that your plan is sound. By charging the wage-earners a small percentage of their income it looks as though the charity angle is taken away and that was my primary objection to "socialized medicine."

We all like to feel independent and want to pay for what we get. I feel that your plan of charging a pro rata share of the wage-earners' income is a very good one.

Thanks again for your letter and with kindest regards, I am,

Very truly yours,

February 1, 1949.

Senator Claude Pepper,
Washington, D. C.

Dear Senator: You are aware, no doubt, of the "fighting fund" which the "leaders" of my profession are collecting in order to combat the "menace" of public medicine.

A whispering campaign is being waged at this very hour in many doctors' consultation rooms and waiting rooms. The "men in white" are determined to defeat decent public medicine by frightening their patients and by persuading them that medical care without direct fees would not be good medical care.

Frankly, I am ashamed of the leaders of the medical profession who have taken the stand of "the doctors versus the people." I am one of the few doctors—and maybe not so very few—who believe that in this struggle between the people and a money-minded profession, the people will win.

You know, of course, that public education had to pass through the same phases. It, too, had to wage a bitter fight against the independent, rich teachers of its time. But the people did win. We now have public education that is free to all. No money is exchanged directly between pupil and teacher.

And the people can win again with the aid of sincere, public-spirited men like you who have the interests of the majority of the American people at heart. Even those who differ on other issues, will agree that we can and must rid our Nation of its worst enemy—fear of sickness—fear of the expense of sickness.

The red herring of socialism is, of course, sheer nonsense; for, if public medicine is socialism, so is our public police department; so is our public fire department; so is our public sanitation department. You know that all of these essential services have nothing to do with socialism. I am sorry to say that many of the leaders of the "medicine machine" who appear so concerned about the health of the people are really worried only about their pocketbook.

I have studied this problem of public medicine over a period of years; I have interviewed doctors; I have participated in public debates on this question of private versus public medicine. And I have come to the conclusion that most of the doctors in this country would welcome a Federal health measure similar to the Workmen's Compensation Act, with which you are, of course, familiar. In other words, let every citizen of the United States have the right to go to any doctor he chooses, just as any injured worker can go to any doctor he selects. No money is to be exchanged between doctor and patient. The doctor merely sends his bill to the Federal health authority and he is remunerated according to a set schedule of fees.

Nothing can be simpler. This is being done every day in the week in every State in the Union. The Workmen's Compensation Act is no longer called socialism. When it was first proposed, you will remember, it, too, was labeled "socialistic."

A legislator has many responsibilities, and too little time. No one man can be an expert in all the fields of our complex life which come up for his consideration. But one can arrive at a just decision by comparison: If you are against the Workmen's Compensation Act, then you will, of course, vote against public medicine. If, however, you are for the Workmen's Compensation Act, then you will see that a Federal health measure along these lines is health—the American way.

Yours for a healthy America,

——— ———.

———, *April 22, 1949.*

Hon. CLAUDE PEPPER,
United States Senator from Florida, Washington, D. C.

DEAR MR. PEPPER: I have followed your efforts to bring about a national health law. As an old member of the AMA, I am supposed to be against it.

I am writing to tell you that the State Medical Society of ——— is rotten. The records show something that they would not like you to know. What they did was something as un-American as possible. It was AMA in action.

Would you like to know?

Yours truly,

——— — ———.

(Separate and identical postal cards addressed to:)

Hon. HARRY S. TRUMAN,
White House, Washington, D. C.

Hon. CHARLES E. BENNETT,
House Office Building, Washington, D. C.

DEAR SIR: It is my belief that American medicine as it is practiced today has been the leading factor in placing the health of the people of the United States above that of any other great nation. The advancements which have made this leadership possible could have resulted only from the strong desire for scientific improvement and the individual initiative which exists in systems of free enterprise.

For this reason I am not opposed to any form of compulsory health insurance.

Yours very truly,

Signed ___________________________
Address____________________________
City and State______________________

———, *June 2, 1949.*

Hon. CLAUDE PEPPER,
Washington, D. C.

DEAR SIR: It is encouraging to know you sponsor the health-insurance program.

Propaganda against it is rampant in ——— County. The enclosed cards may be picked up in doctors' offices. The medical association is active while the rest of us are dormant or nearly so waiting to see what's going to happen and not knowing how to prevent it. Propaganda is poisoning the minds with absurd stories. If the words "nationalized medicine" could be used instead of "socialized medicine" it would help as the word "socialized" has much the same effect and fear as "communism."

Thanks for helping a slow-to-action public who need help and who have little ways and means to help themselves.

Keep the good work up. Thanks.

Respectfully yours,

——— ———.

[Article from ———, ———, May 29, 1949]

Oldtime Medic Charges Profession With Hoodwinking Ignorant Public

Editor, the ———: As a practicing physician since 1913, I must agree to a large extent with a recent letter which referred to doctors and dentists as "money hungry and selfish." Of course, there still exists a small percentage among us who do not warrant such characterization.

The high-cost-of-being-sick bugaboo forms a two-edged sword. First, it is the existing system of handling the sick that makes for seeming high costs in this field.

Second, it is the public's own fault, or perhaps ignorance, which makes the evil possible.

It's much like gambling—no gambler can live unless a horde of victims voluntarily patronize him.

I allege that the people, through subtle propaganda, are being hoodwinked into the belief that accurate diagnosis and treatment depend on lengthy diagnostic measures followed by expensive treatments.

Here is just one concrete example of this system. A few days ago I saw a child suffering from a relatively mild form of epilepsy, which I diagnosed in 10 minutes. The parents told me that they had just spent $179 for a similar diagnosis made by a group of specialists after a week's observation.

Only one of these specialists was recognized as such by any examining board governing medical specialists. Moreover, the genuine specialist charged less for his services than the three other self-styled experts.

For their money, the parents had nothing to show except a prescription for a trade-marked brand of phenobarbital for which the druggist must charge about 5 times as much as for a nontrade-marked brand of the identical drug.

If such is modern scientific medicine, then I'm glad to remain an old-fashioned medical practitioner.

But let me point out that none of these money-grabbing doctors pulled this child into their offices or into the hospital. The parents consulted this group largely upon the strength of the big front they put up and their heralded hospital connections, which give them unwarranted prestige in the eyes of their prospective victims.

To remedy the situation, the public is in dire need of proper education in this field—and by proper education I do not mean syndicated material sent directly from Chicago, or direct propaganda from any single group allegedly representing all medical practitioners—largely through coercive means.

As I see it, the only adequate partial remedy is acceptance of the compulsory health insurance bills now before Congress. That would at one stroke lower general medical fees and annihilate the horde of self-styled specialists whose chief aims are to mulct their patients out of fees which their services do not warrant.

——— ———.

Senator Donnell. Mr. Chairman, at this point I should like to put into the record a booklet which the Chamber of Commerce of the United States has put out on this subject, and I do not suppose it is at all ashamed of having put it out, entitled "You and Socialized Medicine—The Basic Facts and a Call to Action." And on the inside, Freedom Is Everybody's Job. I ask this booklet be incorporated in full at this point in the record.

Senator Murray. It is so ordered.

(The booklet referred to is as follows:)

YOU AND SOCIALIZED MEDICINE—THE BASIC FACTS AND A CALL TO ACTION

FREEDOM IS EVERYBODY'S JOB

(Chamber of Commerce of the United States)

Top administrators of the Federal Security Agency have a plan for socialized medicine in America.

The White House has approved the plan. The Security Agency officials are trying their utmost to get Congress to put it into effect.

Doctors are alarmed. But the issues involved concern us all.

It sounds simple

The proposals for national health insurance, as the Government officials call it, are deceptively simple, as presented.

1. You would pay a special tax, in about the same way employers and employees now pay social-security taxes.
2. You would get back from the Government—if you are eligible—medical and dental care, hospital and nursing service, drugs, spectacles, crutches, and so on.

This plan, its proponents say, would "assure that all people receive needed health and medical care."

But it isn't simple

But socialized medicine is not as simple as it is made to sound. Just how sick would you have to be, for instance, before you could have a private nurse? Or could see a specialist?

There are countless thousands of such questions, each needing some kind of answer.

The bill now in Congress for socialized medicine—Senate bill 1679—is 163 pages long. Yet it scarcely begins to spell out the plan. Mostly it just empowers the Federal officials to issue regulations.

Hundreds of regulations would be needed. The British had to have a volume 1,300 pages long to contain all their official decrees

Who wants socialized medicine?

The first socialized medicine plan was launched by Bismarck in Germany in the 1880's.

It gave an idea to a little group of dreamers in the United States. For about 35 years now, the plan proposed for our country has been evolving.

In the past few years practical politicians have been exploiting the plan as a means of getting votes. And if they can force it through Congress, they will gain great power.

Voters are led to believe they would get complete medical service for nearly nothing. Of course, people favor this—if they don't ask whether it's possible.

The politicians make the plan even more beguiling by playing up two false arguments. First, they say, there is a serious health crisis, with a socialized medicine law the only way to meet it. The selective-service statistics, they add, prove that the need is urgent.

Then they tell us that most Americans cannot afford proper medical care. But we could easily meet the costs—they say—through compulsory Government insurance.

The alleged health crisis

The Federal officials who want socialized medicine keep on talking about this "crisis" in health. American conditions, they say, are "shocking."

Actually, the Nation's health is extremely good. If we compare present health conditions with those of a generation ago, the improvement is phenomenal.

For instance, under 1901 mortality rates, only 750 persons out of every 1,000 born lived to reach age 24. But now, 750 out of 1,000 will reach at least age 59—a life span nearly 2½ times as great, achieved in less than half a century.

As for how we compare with other nations, an impartial research organization—the Brookings Institution—recently made a careful study of the subject at congressional request. Here is the conclusion:

"The United States * * * is among the most healthful nations of the world, perhaps the most healthful of the large nations. * * *"

The statistics behind this statement are truly impressive. As an example, the United States, with 6 percent of the world's population, has more hospital facilities than the rest of the nations put together.

Misuse of draft statistics

But what about the draft statistics? Didn't they reveal a distressingly high proportion of our young men as unfit to serve their country?

So the proponents of compulsion would have us believe. Among many widely publicized statements, the Federal officials have told Congress that "half to two-thirds of the defects revealed could have been prevented or rehabilitated with timely care."

But such assertions do not stand analysis. Dr. Leonard Rountree, who served as chief medical officer of the selective-service system, is one expert who analyzed the figures. So, too, did Dr. Lowell S. Goin, of Los Angeles, and Dr. Maurice H. Friedman, of Washington, D. C., both of whom testified before Congress on the subject.

Dr. Rountree found that only about 15 percent of the rejections were for remediable defects. And even this figure assumes that the rejectee would have sought medical care, that he would have followed the doctor's recommendations, and that the treatment would have been successful.

Dr. Goin and Dr. Friedman reached similar conclusions. "How shall the amputated leg be restored," asked Dr. Goin in his testimony, "and who knows how to cure optic disease?"

More than a third of the rejectees were mentally deficient from birth. "Even a very slight knowledge of eugenics," added Dr. Goin, "will persuade anyone that this group does not constitute a medical-care problem."

Dr. Friedman called attention to the many "structural abnormalities rather than diseases" which led to rejection. "They might be minor things," he said. "A man might have the tip of one finger knocked off or something of the sort."

In summing up his figures for Congress, Dr. Friedman added:

"Any statement to the effect that one-half to two-thirds [of the defects found] were preventable or remediable is utterly false."

Besides the three doctors, experts at the Brookings Institution have also studied the draft figures; they conclude—

"Although the * * * so-called draft statistics * * * have been widely used to show bad health among the American people * * * they are unreliable * * * and cannot be used to show the extent of the medical needs of the country."

Can we pay for medical care?

"Sixty-eight million Americans," say the Federal Security officials, "cannot possibly afford" to pay their medical bills. It is "utterly absurd," these officials insist, to think that families with incomes under $5,000 can purchase adequate medical services.

Actually, most Americans can pay for medical care. Practically anyone who can meet his other bills can meet his medical bills as well, if he chooses—either directly or through insurance.

In 1947 the American people spent $10,000,000,000 for liquor, $4,000,000,000 for tobacco, and over $2,000,000,000 more for cosmetic items—to mention only a few nonessentials. In the same year they spent $1,700,000,000 for physicians' services.

If Americans wanted to double, or even triple, this $1,700,000,000 they could easily do so by cutting down a little on unnecessary things.

The issue is not whether we can afford medical care, says the Brookings Institution, but whether we "should be compelled by law * * * to give payment for medical care a top priority."

Of course, a serious illness with a long period of hospitalization will result in a large bill which the average American cannot meet out of current income. But only a small proportion of people are faced with such bills at any one time.

The obvious answer is insurance, which is simply a device for spreading risks over groups of people and over periods of time. But insurance need not be compulsory nor Government run.

Indeed, most persons who want insurance protection against health hazards, and are willing to pay for it, can buy it right now. Blue Cross, Blue Shield, other nonprofit plans, private insurance companies—all have health protection for sale.

And insurance against sickness would be neither better nor cheaper if we were compelled to buy it from a Government monopoly, a monopoly which, supposedly to pay the benefits, would socialize our entire health machinery.

The needy

There is certainly a small proportion of people who cannot afford to pay either medical bills or medical insurance premiums. In the main these are people who cannot pay for other necessities either.

Medical care for such people, as well as their other necessities, should be provided through Government aid or through private charity. To the extent that present laws are inadequate, they should be strengthened.

But the fact that needy persons must be helped to meet their medical bills is hardly a valid reason for a compulsory Government program applying to the rest of us.

If it were, then by the same logic the Government should furnish all of us with all our necessities. Instead of pay checks, we would get groceries, living quarters, and so on.

The doctors' views

Apart from the talk of crisis, and whether we can afford medical care, would the socialized medicine plan work?

Most doctors, and others who have studied the proposal impartially, say "no."

But, some people argue, the doctors are not impartial; they are just afraid they would not make as much as they do now. This, however, is not so.

Even Oscar R. Ewing, head of the Federal Security Agency and chief Government spokesman for socialized medicine, says:

"All doctors * * * will participate in fixing the fees. There's no doubt in my mind that the group as a whole will make a great deal more money."

In the main, Ewing's statement is confirmed by foreign experience. While highly capable doctors may make less than in private practice, many physicians do make a great deal more.

Why, then, do almost all American doctors oppose socialized medicine? The answer is straightforward: Their profession, they feel, is entrusted with the job of looking out for our health; socialized medicine, they know, would be low-quality medicine in America as it has proven to be elsewhere.

Bad medicine

There are many specific reasons why socialized medicine would be bad medicine in the United States. Here are some of the chief ones:

1. *Shortage of doctors.*—There are only about 190,000 practicing doctors in our country.

This number cannot readily be increased. It takes 10 years or more of college and postgraduate schooling to train a doctor. And the medical schools cannot readily be expanded.

So, for some years to come, we must get along with approximately our present number of doctors, most of whom are already overworked.

Yet under socialized medicine, thousands of physicians would be pulled out of general practice to fill administrative jobs with the Government. And those who remained in practice would spend perhaps an hour a day doing the paper work the Government would require.

Obviously, the amount of time doctors could devote to treating patients would be cut down. Either some patients would have to do without medical care, or all patients would receive superficial treatment.

2. *Malingerers and hypochondriacs.*—Still worse is the problem of malingerers and hypochondriacs.

A malingerer is a person who pretends to be sick—to get sick pay, social-security benefits, or the like. A hypochondriac is a person who really thinks he is sick—but isn't.

There are thousands of such persons. At present they are more or less held in check by having to pay directly for any medical services they demand.

But under socialized medicine, this check would not exist. And trouble would come because the doctor frequently cannot tell whether something is the matter or not.

So physicians would have to waste untold hours treating imaginary ailments, while their bona fide patients would be suffering in the anteroom. Yet the pay-roll taxes of the bona fide patients would be meeting the bill.

3. *How would the doctor be paid?*—There are three known methods of paying doctors under socialized medicine—fee-for-service, capitation, and salary. None of them works satisfactorily.

(*a*) Fee for service: Under this system a price is set for each service. The doctor lists what he has done, adds up the bill, and sends it to the Government. This is the system we would probably start with in our country.

On a fee-for-service basis the doctor is encouraged to cater to malingerers and hypochondriacs. The more he renders trivial or useless services the more he makes. Quick, superficial treatments tend to be the rule. The number of calls, and hence the costs, increase. Serious illnesses are apt to be neglected.

(*b*) Capitation: This is the system the British use. Under it the doctor receives a fixed monthly payment from the Government for each person on his list. His income for a month is the same, whether he does a lot of work or none at all. This system encourages the doctor to do just as little as he can get away with. Those who squawk the most are apt to get the most service.

(*c*) Salary: Finally, the doctor can be put on a straight salary. This is done in Russia. Whether the doctor is highly capable or mediocre, energetic or lazy, his salary may well be the same.

Under this system the doctor loses his incentives and tends to become a plodding civil servant, waiting for pay day.

4. *Destruction of present relationships.*—Apart from the individual doctors, there are thousands of organizations active in the field of health. Included are research laboratories, cancer societies, special sanitariums.

These organizations cooperate closely with one another and with individual doctors. It is this cooperative pattern which is mainly responsible for America's rapid health progress. Yet socialized medicine would destroy present relationships in the vain hope of short-cut gain.

5. *Let's look at the record.*—The Government already provides some medical care for 24,000,000 persons—servicemen, veterans, Indians, and others.

The job is not done efficiently. Recently the distinguished Hoover Commission on Organization of the Government, after a thorough study, stated—

"Federal medical activities are devoid of any central plan. Four large and many smaller Government agencies obtain funds and build hospitals with little knowledge of and no regard for the others. * * * No one has responsibility. * * *"

For example, in San Francisco it was found that 7 of the 13 Federal hospitals might better be closed. "Their closing would reduce bed capacity by about 20 percent and still leave the remaining six hospitals—even after transferring to them the patients from the seven closed hospitals—with only 54 percent of constructed capacity occupied."

Duplications, inefficiencies, and, in particular, wasteful use of scarce medical personnel, were found everywhere.

Apart from all other reasons, the Government's past failures in the medical field suggest an even more dismal failure if a compulsory health-insurance law is enacted.

The past failures show that politics and medicine just don't mix. In addition to bad administration, the ties between doctor and patient are weakened.

The doctor must obey the instructions given him by the politicians entrenched in the high Government posts. In many situations he is not free to use his own judgment. Nor even to treat the patient as an individual.

What would it cost?

With the doctors making a great deal more money, socialized medicine would be expensive medicine.

For a few years pay-roll taxes at the proposed rate of 3 percent (1½ percent each on employer and employee) might pay for the incomplete services to be offered at the outset. But continuing heavy increases in cost are found in all foreign systems.

According to one leading actuary who has specialized in the subject: "The ultimate cost of such a system in the United States might well reach 8 percent or even 10 percent of the covered pay roll."

Who would pay this bill? Certainly there would be heavy pay-roll taxes on both employers and employees. Also a big Government subsidy.

But we can dig deeper here. While the employee may pay his tax himself, the employer much recoup his tax from someone else if he wishes to stay in business. Usually the consumer pays in the form of higher prices.

Likewise, the Government has no independent funds for subsidies. It gets money directly by taxes or indirectly by inflationary budget deficits. Either way the consumer pays again.

So through pay-roll levies, higher prices, and taxes in general, all of us together would have to pay the entire costs of socialized medicine.

Nor is this the whole story. Other social-security costs, which may reach 15 to 20 percent of pay roll should be added in.

Think what it would mean to devote a quarter or more of our incomes to these Government insurances, on top of the big slice for income and other taxes.

Moving toward socialism

A socialized-medicine system would be a big step toward socialism in general. A huge new Government bureaucracy would be created and there would be widespread destruction of our voluntary institutions.

Not only doctors, dentists, and nurses would be paid—and controlled—by the Government but countless typists, bookkeepers, and investigators would also be required.

This new army of Government workers might number a half million persons or more. It could wield dangerous political power.

Meanwhile the many insurance organizations now active in the health field would be destroyed. Yet vast numbers of health policies have already been sold, with millions of new policyholders each year.

And the research laboratories, special sanatoriums, and the like, would increasingly be forced to take the Government's orders.

What you can do

All in all, socialized medicine is one of the most serious threats to the national welfare now pending in Congress. Such a law would injure the health of the people and jeopardize our traditional liberties.

The Chamber of Commerce of the United States, therefore, urges you to make an all-out effort to help defeat this scheme.

Most of us, though, are not satisfied merely to be against something. While socialized medicine must be opposed because it is a move in the wrong direction, let us help build an even healthier America.

Here are some things you can do:

Supporting health progress

1. Remember that the local community is the focal point in health progress. Take an active part in the voluntary health activities of your community.
2. Support desirable local legislation in your community. In particular, see that ample legal provision is made for the medical care of the needy.
3. If you are an employer, try to establish a plan protecting your employees against wage loss when sickness strikes. And explore the possibilities of group insurance as a means of helping them meet hospital and medical costs.
4. Finally, safeguard your own health, look to the health of your dependents, and make proper provision for meeting your health bills.

Opposing socialized medicine

1. Familiarize yourself with as many facts as possible about socialized medicine, so that you will be on sure ground in discussing the subject. Talk to your doctor. Write us at the national chamber if you need help in assembling material.
2. Work with your local and State chambers of commerce in acting to defend America against the dangers of Government medicine.
3. See that your civic clubs and other organizations are alert to the issue.
4. Actively urge your Senators and Representatives to oppose this threat to our health and way of life.
5. Through letters, meetings, personal conversations, make yourself a center of influence in the fight to defend our health achievements.

Senator DONNELL. May I ask two questions? Are we going to have these other witnesses who are listed today?

Senator MURRAY. It is a quarter after one now, and we will be back at 2:30 to hear them.

Senator DONNELL. And I wanted to ask the chairman also: I do not know whether anyone on the committee will have any letters or anything else to put into the record, but I should like to have it understood that until the record is closed any member of the committee may cause to be inserted with the approval of the chairman—I think we should submit them to the chairman—any letters or other documentation he desires to use. If there is any disagreement between the chairman and the person so offering, the person so offering may have the opportunity to be heard before the Committee on Labor and Public Welfare as to the inclusion of such controverted items.

Senator MURRAY. I think we should set the date of July 15.

Senator DONNELL. That is satisfactory, Mr. Chairman.

Senator MURRAY. Then it is so understood.

I have always tried to restrain myself from putting too many things in the record, but a constituent of mine has asked me to submit this. It is a little sticker apparently issued by physicians to patients, and it reads:

> As your personal physician I oppose compulsory health insurance because it would bring you inferior medical care at high cost, invade your medical privacy, put both of us under political control. If you agree, please write to your United States Senators and Representatives. For more information ask me.

I think there is altogether too much education going on of that character which I do not think is the proper kind of education of the public. But nevertheless it is here, and I guess we are able to withstand it without too much trouble.

Thank you, gentlemen, we will come back here at 2:30 p. m.

(Whereupon, at 1:25 p. m., the subcommittee adjourned, to reconvene at 2:30 p. m., of the same day.)

AFTERNOON SESSION

Senator MURRAY. The hearing will come to order. We will proceed with the testimony. Mr. Angus McDonald is here. You may take the stand, Mr. McDonald.

Mr. McDONALD. Shall I proceed, Mr. Chairman?

Senator MURRAY. Yes, you may proceed.

STATEMENT OF ANGUS McDONALD, ASSISTANT LEGISLATIVE SECRETARY, NATIONAL FARMERS UNION

Mr. McDONALD. Mr. Chairman, as a representative of the National Farmers Union I am here to state the position of my organization in regard to S. 1679 which provides for a program of national health insurance and public-health devices and which will assist in increasing the number of adequately trained professional personnel and in the building of new hospitals and other health facilities.

Before I comment on the specific provisions of the bill I would like to make a few remarks in regard to rural health conditions in order to indicate that there is a great need in rural areas for a general insurance health plan. I would also like to read a few excerpts from communications I have received within the last week from Farmers Union leaders and rank and file members.

It is generally agreed that people in rural areas suffer greatly because of the lack of doctors, nurses, hospitals and other health facilities. Before the war large cities averaged 1 doctor to every 650 persons. Predominantly rural counties average about 1 doctor to 1,700 persons and this proportion has grown even greater during the last few years.

Doctors generally tend to locate in towns and cities not only because the remuneration is much greater in areas of relatively dense population but because a well-trained doctor simply does not have adequate hospital and other medical facilities in rural areas to efficiently carry on his profession. All evidence points to the fact that the more rural an area is the fewer the doctors, hospitals and other health services.

This lag in the development of health services has been felt for many years. Fifty years ago, the urban death rate was 50 percent higher than the rural rate. But since that time the rural death rate has fallen so slowly that the urban rate has now overtaken it.

The lowest infant death rates are found in the larger cities. Sixty percent of the Nation's children live on farms and in towns less than 10,000 but only 4 percent of the pediatricians live in such areas.

The existence of such conditions has long been known to the members of the National Farmers Union. Their realization of the need of some kind of Federal action has translated itself into resolutions adopted by local, county, State and national bodies of the National Farmers Union. Let me read to you an extract from the resolution on health adopted at our last national convention held in Denver, Colo., March 1949:

> (a) *Health insurance.*—Universal health insurance legislation should be enacted by Congress. Each person should be covered by health insurance, either in a Federal plan locally administered, a co-operative plan, or a private plan of the family's choice. There is no other way to underwrite the costs of medical service.
>
> (b) *Federal aid in hospital construction.*—The corporations of the cities siphon wealth out of the rural country-side. Some of this money should be put back into rural communities in the form of money to build hospitals. The location of hospitals should be according to a sound over-all plan. The plan should include local health centers, general hospitals, and large medical centers.
>
> (c) *Public Health Service.*—The work of the Public Health Service should be greatly expanded. We favor the spending of $2 per person per year to prevent illness and disease, for health education and for sanitation.
>
> *The medical monopoly.*—We condemn those medical associations, national and State, which constitute a monopoly through the practice of restricting the supply of doctors and opposing necessary public measures to improve medical and hospital service. We believe the medical affairs in each State should be guided by a State Health Council, composed of laymen and doctors.
>
> *Aid to medical students.*—We recommend aid through scholarships or otherwise to medical students who will agree to at least 5 years of service in areas where the number of doctors is deficient. This same method should be used to secure additional nurses in areas where needed.

Somewhat similar resolutions have been adopted by the Farmers Union delegates at State conventions. The attitude of the membership of the National Farmers Union toward national health insurance, as far as I have been able to ascertain, has not changed since any of these resolutions were adopted. This is evident from a number of letters which reached the Washington office in the last few days after it became known that Farmers Union witnesses were scheduled to appear before this committee.

Before I finish reading quotations from these letters, I would like to read two telegrams to the committee which came in after this statement was composed. I will read first the telegram from Great Falls:

> Our great distances, the low and insufficient incomes in some of our rural areas together with the lack of sufficient doctors makes proper clinical attention

an impossibility for rural people. This creates a condition which makes hospital insurance a necessity for the care of the health needs of rural people. Our members are convinced that a plan which will guarantee hospital and medical services to low income people is one of our most urgent needs. Only through a compulsory plan supported by employee and employer contribution can we be assured of sufficient funds to properly care for the health needs of low income groups in rural and urban areas.

MILDRED K. STOLTZ,
Director of Education, Montana Farmers Union.

Senator MURRAY. Are you familiar with the situation in that county, Cascade County, Mont.?

Mr. McDONALD. No, Senator, I am not.

Senator MURRAY. I just noticed an article in the press the other day to the effect that the cost of care for the indigent in that county jumped up from $4,000 to $51,000, and I was wondering how that could be accounted for. I notice that the doctor who was the county doctor there is declining to be a candidate for reappointment, and I was wondering what the situation is there, how it could jump so greatly—from $4,000 to $51,000 for the care of the indigent.

Mr. McDONALD. I do not have any information in that regard on Montana. However, I do know that unemployment is increasing in many areas in the United States and in localities we have had severe unemployment for some time. For example, in southern California I understand the relief rolls have gone way up during the past several years.

Senator MURRAY. Of course this is for the year 1948, and during that period there was no unemployment. I just could not understand why that great increase should be found in the cost of indigent care, unless there was something dishonest or corrupt about it, some padding of the rolls, or something like that which occurred.

Something along the same line occurred during the depression in the 1930's where the WPA was assisting people who were unable to pay their medical bills, and the bills were padded. I was wondering what the situation was here. You do not know anything about it?

Mr. McDONALD. I am sorry, Senator, I do not.

Senator MURRAY. Go ahead.

Mr. McDONALD. Now I would like to read another telegram received yesterday from the Minnesota Farmers Union. The Minnesota Farmers Union wired as follows:

The Minnesota Farmers Union has year after year, has clearly and concisely recognized the great existing need of developing better and more adequate health insurance in the rural areas of Minnesota. Health should be the Nation's No. 1 problem and should be geared to a program in such a fashion so as to include everyone but particularly the people that are in a position least able to afford it. Further than that, universal health insurance should be enacted by the Congress of the United States based on a system supported by deduction off employees and employers rather than a charity system. An assistant legislative secretary of the National Farmers Union we most heartily encourage you to present our views on this matter and our support of the President's health insurance proposal, S. 1679.

MINNESOTA FARMERS UNION,
EINAR KUIVINEN, *President,*
ALICE VAN DYKE, *Educational Director.*

I will continue now reading a few brief extracts from letters recently received on this subject. Here is one dated June 23, this year, from Mrs. Esther Harbo, director of education, Rocky Mountain Farmers Union:

> I have found sentiment rapidly increasing in favor of President Truman's health insurance proposal (S. 1679). Members of our organization, and their farmer friends, too, feel that a program which will include everyone is most desirable. Support of the system by deductions from the income of employees and employers is viewed as the fairest and most logical method.

Here is another quote from a letter received from Paul Opsahl, president of the South Dakota Farmers Union.

Senator MURRAY. These are along the same lines, so it will not be necessary for you to read them. They will be printed in the record. You need not read each one of them. It is not necessary for the purpose of the record.

Mr. McDONALD. Also I would like to submit for the record letters from which I have quoted, also an additional letter received from farmers and others. We have quite a long list of names here.

Here is an example, a group of farmers who got together and signed this statement, and I would like, if it will not burden the record too much, to have this material in the record.

Senator MURRAY. They will all be printed in the record.

Mr. McDONALD. I might refer, in accordance with your suggestion however, to the authors of these letters. The following people have written me in regard to S. 1679 urging that it be approved by the Congress:

Paul Opsahl, president of the South Dakota Farmers Union; Aubrey Williams, of the Alabama Farmers Union; Dora Barney, director of education, Oklahoma Farmers Union; Lyle Thomas, secretary, Oregon State Farmers Union; and I have already referred to the two received from Montana and Colorado.

In addition I would just like to mention the names of the farmers who have written in to us.

Here are a few of them: F. M. Harrison, Route 10, Greenville, Tenn.; Earl Gobble, Route 3, Abingdon, Va.; E. H. Thomsen, Route 3, Huntingdon, Tenn.; Mrs. J. Lynch Jones, Route 7, Greenville, Tenn.; A. C. Lange, Route 2, Huntingdon, Tenn.; H. N. Hatley, Baileyton, Tenn.; H. H. Mathews, Farmers Union Fertilizer Cooperative, president board of directors, Andalusia, Ala.; H. L. Cobb, Route 4, Andalusia, Ala.; H. R. Owens, Andalusia, Ala.; J. D. Mott, Covington Co., president, Farmers Union, Andalusia, Ala.; L. H. Cobb, Andalusia, Ala.; Myles Horton, representative of the National Farmers Union for Tennessee and Virginia; Mrs. Frances Leber, educational director of the eastern division of the National Farmers Union, headquarters at Trenton, N. J.

I omitted mentioning these last two in the first group of officials who had written.

Now I will resume reading of the statement.

As indicated, my organization and its members are heartily in favor of the purposes of the bill. Moreover, we believe that S. 1679 provides the best practical method to bring an adequate comprehensive medical system to our people. We note with approval that provisions are made not only for a method of financing it by setting up an insurance fund by means of deductions from salaries and wages similar to the social security fund but because the bill provides for the expansion of medical facilities including the training of doctors, the building of hospitals and other health facilities. It seems to us in the

Farmers Union that the simple way to finance a health plan is to deduct from each pay check a small amount by the employers and that the Government should take this money, set it aside and make it available for use by the contributor when the inevitable sickness comes.

We do not believe that voluntary plans will work because many of the young and healthy and the well-to-do will not join in with any general plan. Only those persons who are relatively bad health risks will enter. And while we realize that those with a relatively high income must at least in part contribute to the health fund which is used for the indigent and those in the very low income groups we feel the taxpayer has to pay a part of the health expenses of such people anyway.

Furthermore, we feel that this proposed legislation has several advantages over some of the substitute plans before this committee. Individuals participating in the health insurance plan proposed here will not be required to take a humiliating means test for the simple reason that practically everybody will be included in the plan.

We also approve the provisions in section 703 which provides:

> Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital, or other person of his choice to render such services, and may change such selection: *Provided*, That the practitioner, medical group, hospital, or other person has agreed under part C to furnish the class of services required and consents to furnish such services to the individual.

We take this provision to guarantee not only free choice of the patient but the right of the doctor to reject any patient that he chooses.

We believe that this bill will not weaken the high standards of the various medical associations. As we understand this legislation, doctors still decide strictly medical matters. Naturally we feel that all medical matters should be determined by the members of the medical profession. All courses of treatment, all requirements as to which individuals are qualified to carry on a medical practice should continue to be determined by members of the medical associations. People whose money will be spent under such a program should have a voice in determining how it is to be spent. Well-qualified physicians and surgeons in many cases would probably not make good administrators. There is a tendency for some doctors to feel that if lay people have a voice in the administration of health plans that it will in some way interfere with their efficiency as doctors. They therefore work to prevent any plan from going into effect which is promoted by lay people. We feel that doctors are mistaken in this view and that they would be left free under this bill to fully carry on their medical practices as they have in the past. Furthermore, in all probability, many doctors would receive, especially those in the lower brackets, a far greater compensation than they do now because this bill would bring medical service to many millions of additional people who are now unable to pay for it.

We note with special approval a provision in the bill which provides for assistance for farmers' experimental health cooperatives. Due to lack of health services and sparseness of population, there is a great need for health cooperatives in rural areas. Many rural people are vitally interested in the setting up of such projects and I am sure would welcome enthusiastically this proposal of the Federal Government to assist farmers in selected areas to initiate and carry out experimental plans for providing medical care for the members of the cooperatives. Farmers Union officials and members have had much experience over the years in setting up cooperatives and many of them feel that this experience will be valuable in aiding the building of health cooperatives.

In conclusion, I would like to urge members of this committee to give favorable consideration to S. 1679. As stated above, we believe that it is needed, that it is practical and that it would not interfere with the freedom of the medical profession, or patients. We likewise feel, as we also have pointed out, that it would not undermine the high standards of the American medical profession.

Senator MURRAY. That concludes your statement?

Mr. McDONALD. Yes, sir.

Senator MURRAY. In your capacity as assistant legislative secretary of the National Farmers Union, do you feel that you have a pretty good general idea of how the people in your rural areas covered by your organization feel about this matter?

Mr. McDONALD. Yes, I do, Senator. It is true that I spend at least 90 percent of my time in Washington. However, in attending State and national conventions, and occasionally making trips—for example, a year ago I made a Nation-wide trip through every State where we have substantial memberships discussing the legislative plans for this year, and I did not hear a single dissent to the idea that the Farmers Union should back up your bill 100 percent.

Senator MURRAY. And the agitation for legislation of this kind has been going on for a number of years, has it not?

Mr. McDONALD. Yes, sir.

Senator MURRAY. The National Farmers Union has been supporting a program of national health insurance now for a number of years?

Mr. McDONALD. I believe I am correct in saying that ever since a bill of this nature was introduced in the Congress, that the Farmers Union has supported it.

Senator MURRAY. They brought witnesses here from many rural sections of the country who testified about the conditions existing in the field.

Mr. McDONALD. Yes, sir.

Senator MURRAY. And these witnesses from the local areas testified in support of the program.

Mr. McDONALD. As far as I know all of them did.

Senator MURRAY. Thank you very much. The letters you have submitted will be incorporated into the record at this point.

(The documents above referred to are as follows:)

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

Mr. ANGUS McDONALD,
Representitive, National Farmers Union,
Washington, D. C.

DEAR MR. McDONALD: I understand that you are appearing before the Senate committee on the health insurance program, and that there is some doubt in some of the committee's minds concerning whether or not farmers are in favor of this bill.

I want to say that, as a farmer who farms 45 acres of land in south Alabama, that I certainly am in favor of the bill—every bit of it.

My family and myself has suffered from time to time in our lives because we couldn't either afford medical care and health services; or, when we can afford it, we can't get it, because there aren't enough doctors, or they are improperly trained and need more education.

I hope that you will persuade the committee that there are certainly a lot of southern family farmers who favor the Truman health program.

Sincerely,

W. JOHNSON FRANKLIN,
DOZIER, ALA.

JUNE 18, 1949.

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

MR. ANGUS MCDONALD,
Representative, National Farmers Union,
Washington, D. C.

DEAR MR. MCDONALD: I understand that you are to testify on behalf of members of the Farmers Union for the national health insurance bill.

I want to say right here as a member of the Farmers Union, you can speak on my behalf and for all my neighbors around here, to urge the Senate committee to favorably consider the health program. We farmers need every provision of the bill; especially are us farmers in a place where we need better medical and health facilities in our communities. It's getting so that we cannot afford adequate health coverage, nor can we get it even when we can afford it.

Sincerely,

F. H. FRANKLIN,
Dozier, Ala.

JUNE 18, 1949.

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

MR. ANGUS MCDONALD,
Representative, National Farmers Union,
Washington, D. C.

DEAR MR. MCDONALD: I understand that you are to appear before the Senate committee which is considering the Truman health bill and insurance program.

There is one thing I want to say as an individual farmer and a registered voter in my district: I stand unequivocally in favor of the program as outlined in the information we have from the National Farmers Union concerning the rural program inside the national insurance health bill.

As a Negro farmer, I know that our whole community of people needs greater opportunities to get to a doctor, and to get clinical service for eyes, teeth, and many other things.

I hope that you will assure the Senate committee of the importance to us farmers of some kind of a national program of health insurance, and medical aid.

Sincerely yours,

H. D. COBB,
Red Level, Ala.

JUNE 18, 1949.

THE FARMERS' EDUCATIONAL AND COOPERATIVE UNION OF AMERICA,
OKLAHOMA FARMERS' UNION,
Oklahoma City 4, Okla., June 22, 1949.

MR. ANGUS MCDONALD,
National Farmers Union, Washington, D. C.

DEAR MR. MCDONALD: We just noticed in the North Dakota Union Farmer that Farmers Union representatives will testify on S. 1679, the President's health insurance proposal, on June 29.

We want you to go all out on that for the Farmers Union membership in Oklahoma for, as you well know, the health conditions of people in rural areas here are in a sad plight. The program has been widely endorsed by locals throughout the State.

The need for a health insurance system that includes everybody is emperative. Under such a system defects will be detected in childhood and corrected early in life, thus giving society healthy, happy, industrious citizens all through life.

Another feature of S. 1679 that is highly desirable is that it would be supported by pay-roll deductions of employees and employers and so isn't a charity system which is abhorrent to people generally, regardless of their economic status.

We endorse S. 1679 and trust you will give it your unqualified support.

Sincerely,

Dora Barney,
Director of Education,
Oklahoma Farmers Union.

Farmers Educational and Cooperative Union of America,
Alabama Division,
Birmingham 6, Ala., June 20, 1949.

The administration's over-all health bill, S. 1679, is a very great importance to the rural areas in the South. In Alabama, for example, there are hundreds of communities with no clinics or hospitals; with the nearest doctor, 10, 12, and 15 miles away.

A great number of farm families cannot use the facilities we have because they do not have the money to pay. Any plan which hopes to provide adequate medical care must include compulsory health insurance. The existing voluntary group health plans are completely inadequate for the majority of farm families.

The Alabama Farmers Union strongly endorses S. 1679.

Aubrey Williams,
President, Alabama Farmers Union.

Farmers Educational and Cooperative Union of America,
South Dakota Division,
Mitchell, S. Dak., June 11, 1949.

Mr. Angus McDonald,
Assistant Legislative Secretary,
Washington, D. C.

Dear Angus: I understand you soon will be before the Senate Labor and Public Welfare Committee to testify on the administration's health bill S. 1679.

I want to refresh your memory on the fact that the South Dakota Farmer's Union is strong for health-insurance legislation. One of our greatest handicaps out in this country is the lack of health facilities. Beyond that, many of our people find the burden of medical costs too heavy to bear, and I can cite many cases where people have lost their home and farm due to emergency illness in the family.

As we see it there is no other way to solve this situation on a long-range basis, except the use of some form of health insurance administered on a national basis.

I hope you will impress the Senators with this point, if and when you testify.

Sincerely,

Paul W. Opsahl,
President, South Dakota Farmers Union.

Farmers Educational and Cooperative Union,
Rocky Mountain Division,
Denver, Colo., June 23, 1949.

Angus McDonald,
National Farmers Union, Washington Staff,
Washington, D. C.

Dear Angus: In my travels through Colorado and Wyoming as director of education for Rocky Mountain Farmers Union, I have noted the growing need for health insurance particularly in rural areas. Adequate medical care, it appears, is beyond the means of about two-thirds, or even more, of the farm families.

This is doubtless partly responsible for the deplorable lack of doctors and hospital facilities in many areas. A check with the Colorado State Health Department revealed that 20 Colorado counties are without hospitals. In some heavily populated counties it is necessary to drive from 60 to 100 miles for hospitalization—or even for emergency medical attention, in some cases.

There are 11 counties without dentists—counties whose population totals 28,560—and 13 other counties have but one dentist each.

The picture of the lack of doctors is similar—at least a dozen counties have no physician. The 755 dentists of the State have an average age of 52.1 years, which means that many will be retiring from active practice within a very few years.

I have found sentiment rapidly increasing in favor of President Truman's health-insurance proposal (S. 1679). Members of our organization, and their farmer friends, too, feel that a program which will include everyone is most desirable. Support of the system by deductions from the income of employees and employers is viewed as the fairest and most logical method.

Sincerely yours,

ESTHER HARBO,
Director of Education, Rocky Mountain Farmers Union.

FARMERS' EDUCATIONAL AND COOPERATIVE UNION OF AMERICA,
OREGON DIVISION,
Salem, Oreg., June 24, 1949.

ANGUS MCDONALD,
Assistant Legislative Secretary, National Farmers Union,
Washington 3, D. C.

DEAR MR. MCDONALD: The Oregon State Farmers Union is definitely of the opinion that there is need for a health program which is general in application and which will meet the needs of all people.

We are much impressed and distressed with the evidence of lack of adequate health care and facilities in rural areas. There is much visible evidence of that need even in the State of Oregon, where incomes for the past several years have been pretty fair. That we are cognizant of that need in Oregon is attested by the establishment of a cooperative health clinic in this area. While this is meeting the needs of some people, the support is not as general and widespread as it should be. We feel that is time for this type of activity to be furthered, and also to be implemented by governmental action.

It is apparent to us that such health programs as exist in the States and in the Nation today are entirely inadequate and that the time has come for the adoption of a general health-insurance system. We believe that the soundest approach to this system is the provision of a plan by which employees and employers contribute to its operation.

Briefly, our feeling is that there is very considerable need for better health care and that the present systems are proving inadequate. To remedy this we believe that action should be taken on the national level in the absence of adequate programs from the local and State level. In view of these facts, it is our opinion that the national health-insurance proposal embodied in S. 1679 should be adopted.

Yours very truly,

LYLE THOMAS,
Secretary, Oregon State Farmers Union.

FARMERS' EDUCATIONAL AND COOPERATIVE UNION OF AMERICA,
EASTERN DIVISION,
Trenton 8, N. J., June 22, 1949.

My name is Mrs. Frances Leber, and I am education director of the eastern division of the National Farmers Union, representing farm families in the States of New Jersey and Pennsylvania. There is no question in my mind that there is a great need for health insurance, particularly in the rural areas where our members live.

The only form of health insurance to build a citizenry that is physically and mentally developed to the highest American standard is one based on a Federal system, supported by deductions from the income of employees and employers of the Nation. No plan based on piecemeal charity can hope to serve the American people, and particularly the American farm family, in a manner that will reach the entire population.

For these reasons, I wish to endorse Senate bill 1679, embodying proposals for a Federal health-insurance system.

Mrs. FRANCES LEBER.

FARMERS UNION,
TENNESSEE ORGANIZING COMMITTEE,
June 23, 1949.

Mr. ANGUS MCDONALD,
Assistant Legislative Secretary, National Farmers Union,
Washington 3, D. C.

DEAR ANGUS: We endorse President Truman's health-insurance plan (S. 1679) because we have a great lack of hospitals and medical services in the rural areas, and especially in the South. For example, in our own county here in Tennessee we have approximately 16,000 people and no hospital at all.

As it is now, many of our people are receiving inadequate medical care because their incomes do not pay for the present doctor and hospitalization fees. The health-insurance plan would include everyone.

Furthermore, I believe it is desirable to have a system supported by deductions of employees and employers rather than a charity system.

I am enclosing some statements made by a few of our Farmers Union members which are taken from the April issue of the Southern Farmer.

Sincerely yours,

MYLES HORTON,
Representative, National Farmers Union for Tennessee and Virginia.

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

Mr. ANGUS MCDONALD,
National Farmers Union, Washington, D. C.

DEAR MR. MCDONALD: I understand that you are to testify before the Senate committee considering the Truman proposal for a national health insurance program.

I want to say on behalf of 50 Negro families in my community here in Covington County, Ala., that we stand in a great need of the health insurance bill, particularly as that bill relates to measures to improve medical and health facilities in the rural communities.

We need more doctors and we need a program for paying for them and for clinics and for other kinds of health and medicine needs.

I hope that you will urge the honorable Members of the Senate to understand that there are many farmers in favor of the program Mr. Truman is advocating, and that you will urge immediate action by the Senate committee to go on record in favor of this bill.

Sincerely yours,

L. H. COBB,
President, Friendship Local,
Covington County Farmers Union.

JUNE 18, 1949.

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

Mr. ANGUS MCDONALD,
National Farmers Union, Washington, D. C.

MY DEAR MR. MCDONALD: It has come to my attention that you are to testify before the Senate soon concerning the national health insurance bill.

I think this bill is one of the finest and most needed programs in the whole set of bills offered by the administration, and as a farmer, knowing the people of the South, I can say that we certainly need something to improve the health of our people as a whole, especially the farm people.

Without the program as outlined in the bill, it is absolutely impossible for the people to get medical treatment and hospitalization. The special features applying to a rural program, such as clinics, scholarships, and special financing of medical care in the country, make this bill you are to testify about one of paramount interest to small farmers in the South, and I hope that you will urge the Senate committee to approve of every feature of this bill.

A big percentage of rural people go through life with physical handicaps because they are unable to meet the high prices of medical attention.

Very sincerely yours,

J. D. Mott,
President, Covington County Farmers Union.

STATEMENTS ON MEDICAL PROGRAM

Mr. H. L. Cobb, Route 4, Andalusia, Ala.: "I am very interested in the national health and medical program, and we have been talking about it. At present we have practically no doctor's attention at all, and we do get sick. Last year Mrs. Cobb was very sick all during the crop season, and we could not get her any doctor or hospital attention."

Mr. H. R. Owens, Andalusia, Ala.: "We have two hospitals in Andalusia. One is better than the other one, but neither one is too good, and both of them charge too much. What we need here is at least one charity hospital, because lots of people can't pay the price the hospitals ask, and they do need the service. We have some confusion too about the doctors. Of course, they charge too much. I can't exactly blame them, because they are in a position to do it. They are organized. I guess when the farmer is organized he'll be able to charge more for what he sells, too. I think the national medical program is very badly needed here. We have been talking about it, and I am for it."

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

Mr. ANGUS McDONALD,
Representative, National Farmers Union, Washington, D. C.

DEAR MR. McDONALD: We understand, as signers of this round robin letter, that some of the honorable members of the Senate committee before which you are to appear think that farmers are not in favor of the Truman national health insurance bill.

We would like to tell you that the undersigned farmers, all of whom make their living on the farm, are definitely in favor of every proposal of the health bill, and we hope that you will use our names to persuade the committee in the Senate that they should consider very favorably the health insurance bill.

Very sincerely yours,

W. S. S———, Andalusia, route 4; D. C. Clark, route 2, Dozier, Ala.; Vannie Clark, route 2, Dozier, Ala.; J. D. Barrow, Jr., Red Level, Ala., 2285 Main Street; Nola Mae Little, route 5, Andalusia, Ala.; Mrs. Blanche Hart, route 4, Andalusia, Ala.; Miss Merlene Sasser, Dozier, Ala.; W. C. Chapman, Andalusia, route 4; Mr. and Mrs. J. D. Whitehurst, route 6, Andalusia, Ala.; S. E. Bowers, Andalusia, route 3; W. E. Hart, Andalusia, route 4; Artie Smith, route 4, Andalusia.

FARMERS UNION FERTILIZER COOPERATIVE,
Andalusia, Ala.

Mr. ANGUS McDONALD,
Representative, National Farmers Union, Washington, D. C.

DEAR MR. McDONALD: I understand that some of the members of the Senate committee considering the Truman proposal for a national health insurance program are doubtful that any farmers really support the rural features of this bill.

I want to say that as a farmer who still tills the land, and who lives in the country, and who presides over a board of directors in charge of a cooperative with a thousand farm families in it down here in south Alabama, that I know very definitely that the common people in the country are very much interested in this bill. Our very health depends on some kind of a system that will provide better medical care and health facilities for our people.

Please impress upon the committee members of the Senate that you speak for me and my family and my kind of people down here—the small family farmers.

Sincerely yours,

H. H. MATHEWS,
President, Board of Directors.

JUNE 18, 1949.

[From Southern Farmer, April 1949]

ARE YOU IN FAVOR OF NATIONAL HEALTH INSURANCE?

F. M. Harrison, Route 10, Greeneville, Tenn.: "I heartily endorse any program to make medical care available to the forgotten man. That's what Roosevelt called them—those people who may not have the ready money when they need it."

Earl Gobble, Route 3, Abingdon, Va.: "Yes; at the present time, if you have any physical ailment, it is almost impossible to get a doctor unless you go to the hospital. Many of the rural people can't afford to go to a doctor or go to a hospital, either."

E. H. Thomsen, Route 3, Huntingdon, Tenn.: "We've got three doctors here in Huntingdon. One of them has a clinic. He told me that he had 100 patients in last Saturday. We need more doctors and more clinics."

C. W. Marsh, Route 2, Abingdon, Va.: "I think it is a good thing myself. In the last year it would have cost us $25,000 if we had had to pay my daughter's hospital bill. She is in nurse's training, so it didn't cost anything to the family."

Mrs. J. Lynch Jones, Route 7, Greeneville, Tenn.: "That sounds good to me. What can we do about it?

"Not long ago we had to take our son to the hospital. When we took him in they asked, 'Have you got the money to pay for your bill?' Fortunately we did.

"There are a lot of medicines we don't know about until it is too late. There ought to be some way to get information about them out to the people in the country."

A. C. Lange, Route 2, Huntingdon, Tenn.: "The majority of doctors say when you call them 'Have you got the money?' If we, as individuals, can't pay for doctors, the Government should. Who is the Government? It's us.

"Every week I have to go to Nashville for X-ray treatments. Why should a man have to go 106 miles for a 2½-minute treatment?"

Jack Hustead, Abingdon, Va.: "Everybody in America ought to get medical care just like they get schooling. It's going to be a godsend to the little country doctor."

John Carter, Abingdon, Va.: "If the AMA is against it, I'm for it. Common sense would show that they are for their own selves, not for the interests of the people.

"I think everybody ought to get equal medical attention."

H. N. Hatley, Baileyton, Tenn.: "If the AMA has to raise $3,000,000 fighting it, it must awfully popular with the people."

E. B. Reed, Route 2, Greeneville, Tenn.: "I am very much in sympathy with the bill. We have only two rural doctors. Most of the people have to come to town.

"It would have been mighty nice for me in the last 2 years. I paid $550 on myself last year and my two daughters each had to have their appendix out. That was in the neighborhood of $300 each."

Senator MURRAY. Mrs. Jerome Evanson is our next witness. Mrs. Evanson, you may proceed.

STATEMENT OF MRS. JEROME EVANSON, DIRECTOR OF EDUCATION, NORTH DAKOTA FARMERS UNION

Mrs. EVANSON. I am Mrs. Jerome Evanson, of Jamestown, N. Dak., director of education for the North Dakota Farmers Union. As a rural school teacher, and a farm mother, I speak from the standpoint of farm mothers. As director of education for the North Dakota Farmers Union I speak for over 37,000 farm families. I speak out of my experience on the land and experience with my neighbors.

Senator MURRAY. You are not located in some office here in Washington and testifying from mere correspondence or reading the newspapers. You are right from the field and know what the situation is.

Mrs. EVANSON. That is right, Senator.

We in the rural areas of America, represent the areas of greatest need in the way of health facilities and services. We are lacking in all phases of a health program. We need doctors, dentists, specialists, nurses, technicians. We need hospitals, health centers, clinic and mobile units for isolated areas. We should have full coverage of public health services. There is a great need for sanitation around the aveage farm home, better housing with modern conveniences, running water, indoor toilets, sanitary water and milk supply—all the things that those who live in the cities take for granted but that few farm families have. We need to give more consideration to our handicapped in rural areas; to the chronically ill and the aged. We need to give more consideration to maternal and child care; to the health of our school children.

We need more information on soil analysis and the relation of soil to good health. We need to train more of our rural boys and girls in the medical profession.

Now let us say that doctors, nurses, dentists, specialists were provided for the agricultural areas—that we had hospitals within easy reach of every farm home—that we had all of the modern medical equipment to care for our every need that would guarantee adequate health care—it would still be out of reach for most of us under the present system of paying for medical care—medical and hospital care today is prohibitive—a serious illness means the loss of savings, too often the loss of income and a home. Coupled with these facilities and services must be a way of making these services available to all people in the area.

It is a habit of Americans to boast about our high standard of living, our cars and refrigerators, the best medical care and facilities in the world, but what do all these things mean to those millions of Americans who do not have them——

Senator MURRAY. I understand that there is something like 30 percent of the people of the country who earn less than $2,000 a year.

Mrs. EVANSON. Yes; that is right.

Senator MURRAY. And that a great section of our country is not benefited by the knowledge and understanding that a lot of people who have automobiles and are living luxuriously have.

Mrs. EVANSON. What do all these things mean to those millions of Americans who do not have them, or having them available cannot afford them. Health care too often means the sacrifice of a life's savings or years of debt burden—the loss of a home because of the debt, and loss of earning power. Too many homes today are lost because of excessive medical bills, too many people must make too great a sacrifice for health care.

Typical is this couple in their early fifties. They were not interested in a national health plan. They were in good health. She was associate professor at the university. He had a good position. They owned their home, they had a nice savings account of six or seven thousand dollars. They had health and security.

Then very suddenly the husband was stricken. Two years later he was beginning to walk again. Their savings were gone, their house was mortgaged. The wife, a nervous wreck from anxiety over her husband, and worry over their insecurity. It was doubtful that she could continue teaching. These were good substantial citizens. They deserved more than this in their middle age. Voluntary health insurance did not provide them with health care and security. National health insurance would have provided this care and security.

Typical is this family man with a good paying job—good for our area. He makes from $250 to $300 per month. Working evenings on a modest home he was building for his family of five, he was injured in a fall from a ladder. His hospital bill for 9 days was $468. This did not include $30 a day for special nurses for 5 days. Hospital and nurses was $69 per day. His salary is less than $10 per day. Now this did not include the doctor bill. Yes, he had voluntary insurance. It did not pay the complete hospital bill. It did not pay for blood transfusions, or for penicillin, sulpha, and continued treatments for he will be a long time under the doctor's care. Worry has brought his wife on the verge of a nervous break-down. It means not only staggering debts but loss of income to provide for his family and great mental strain that threatens the health of the entire family.

Medical care has become a luxury few can afford. I have spoken to many young married couples who want to have families but can't afford them. One mother said "This baby cost us $384, we just can't afford to have another." She had wanted a family of four. "We had voluntary insurance that paid $25 of the $384." Another said, "I should go to the clinic but I just can't afford it" or "I don't dare go to the doctor. I was feeling ill for several days and consulted my doctor. He sent me to the hospital. I was there for 3 or 4 hours. It cost us eighty some dollars. All I had was summer flu. I'll never dare go back to the doctor again. No matter how ill I may be, we just can't afford it."

There are people who want to have families—who want medical care but find they simply can't afford either. Then there are those who are indifferent and will not spend money to improve the health of their children. The county nurse at our rural school said that little Mary had every indication of TB in the glands of her neck and should be taken to the doctor.

When I consulted the mother about sending her to the doctor she said, "Oh, silly, she'll outgrow it."

A boy needed glasses badly. When the parents were notified the mother said, "No, Carl will finish the eighth grade in 2 months and then he won't need glasses" inferring he would not be reading any more books.

Are these children of indifferent parents to be denied good health care because their parents think it is a waste of money to provide health care for them? These are the people who will never subscribe to voluntary health insurance and their name is legion. We must have a plan whereby these people must participate and provide health care for their children. They pay their share for public schools—and use them—they pay for roads, the courthouse, police protection, fire protection—why not for health protection.

We are grateful to the American Medical Association for the publicity they have given to national health insurance. They with their publicity experts have reached millions of people who would otherwise not be aware of the national-health program. The AMA has made millions of Americans health conscious and has made them aware that efforts are being made to provide ways and means of meeting their health needs but that the AMA is opposed to such plans. The AMA's three and a half million dollar slush fund and propaganda experts are doing a complete job and we do appreciate it. We only regret the tactics they are using to spread misinformation. It is unethical and unwise.

However, the medical association is kidding no one but themselves. They are too well known for their blocking tactics in every State. The medical association has stated they are wholeheartedly for public health services but our farmers remember well when North Dakotans introduced enabling legislation to permit the setting up of public health district units to provide public health services in rural areas. There was only one group that fought the bill and that was the medical association.

In the past two sessions of the legislatures in Minnesota and South Dakota, we have the same story of blocking attempts to get enabling legislation to provide for public health services in rural areas. The AMA today wholeheartedly endorses voluntary health insurance programs—so they say, but they have succeeded in passing laws in more than 20 States that prohibits local groups to organize voluntary health insurance programs. Why don't they pass laws to prohibit lay people from building hospitals? Could it be the cost involved in building hospitals might have something to do with it. These lay-controlled hospitals have a fine record of hospital standards and administration—a much better record in fact than doctor-owned hospitals.

If lay people have such a fine record building and maintaining hospitals why the AMA concerted effort to restrict their attempts to provide health insurance to maintain these hospitals? Could it be that fees for service are involved? Or nonprofit health services for people versus health services for profit?

The AMA is flooding the country with literature and cartoons against a national health insurance program.

I have here a very dilapidated article that was sent in to me which is being spread all over North Dakota.

Senator MURRAY. I would like to have that copied in the record.

Mrs. EVANSON. All right, this is quite a dilapidated one that was sent in by one of the country women. You may have it.

Senator MURRAY. You do not mind losing it?

Mrs. EVANSON. I can get many more of them, I assure you.

(The document above referred to is as follows:)

AMERICAN MEDICINE REPLIES TO PRESIDENT TRUMAN—A DOCTOR'S DIAGNOSIS OF THE PRESIDENT'S COMPULSORY HEALTH INSURANCE PROGRAM

(By Dr. Elmer L. Henderson, Chairman, Board of Trustees, American Medical Association)

President Truman's special message, asking enactment of a national compulsory health insurance program, deserves most careful scrutiny, both by Congress and by the American people, whose health would be seriously endangered if this Old World scourge is allowed to spread to our New World.

There is neither hope nor promise of progress in this system of regimented medical care. It is the discredited system of decadent nations which are now living off the bounty of the American people—and if adopted here, it would not only jeopardize the health of our people, but would gravely endanger our freedom. It is one of the final, irrevocable steps toward state socialism—and every American should be alerted to the danger.

ASSEMBLY-LINE MEDICAL MILLS

Adoption of a system of politically controlled medical practice, as recommended by President Truman, would turn back the clock of medical progress in this country 50 years.

The inevitable deterioration in the quality of care which would result from Government-herding of patients and doctors into assembly-line medical mills would lower the standards of healthy America to those of sick, regimented Europe.

One of the great dangers in political diagnosis of the health needs of the people is the temptation to oversimplification. President Truman has fallen into this error.

The President sets forth an objective which all of us can warmly endorse—namely, bringing adequate health services within the reach of all the people. The doctors of America, in cooperation with the prepaid medical and hospital-care plans and the many splendid voluntary health insurance systems, have made great progress in achieving that objective, so we have no quarrel with the President on that score.

President Truman, however, proceeds from a desirable objective to a highly undesirable proposal for achieving that objective. There is a great deal of double talk in the president's message, but what he actually proposes is a national compulsory health insurance system which would regiment doctors and patients alike under a vast bureaucracy of political administrators, clerks, bookkeepers, and lay committees.

EXORBITANT PAY-ROLL TAXES

Every wage earner, every self-employed person, and every employer would be compelled to contribute exorbitant pay-roll taxes, eventually mounting to a tax of 8 or 10 percent on every pay check, to support this system—and the cost of medical care instead of being reduced, would be doubled and trebled by bureaucratic overhead. The record is clear in every country where compulsory health insurance has been adopted. It is cheap in quality, but extravagantly high in price.

The President's message, in some respects, was persuasive and disarming. The ideals and objectives were stated in glowing terms, but the message was completely lacking in any specific statement of the services to which the people would be entitled, or any estimate of the taxes which they would be compelled to pay.

A BLANK CHECK—FOR WHAT?

Mr. Truman has been too long away from Missouri, if he believes the American people will sign a blank check for such an ambiguous program. The people will want to be shown.

There are many fallacies and misstatements in the President's message, some of which cannot go unchallenged.

President Truman, for example, is about a decade behind the times in his statistics on the growth of the voluntary health insurance systems.

PRESIDENT'S STATISTICS 10 YEARS OUT OF DATE

He reports that only 3,500,000 people have insurance which provides adequate health protection. Ten or fifteen years ago that was true. Today, Mr. President, 55,000,000 Americans are protected, under the voluntary health insurance systems of this country, against the costs of hospital care, and 37,000,000 policy-holders are insured against surgical or medical bills.

Again, the President falls into the error of stating that only limited, inadequate health protection is available under the voluntary health insurance systems. Actually, the voluntary systems are providing better coverage today than any compulsory program yet proposed—at about half the price.

President Truman also makes the amazing assertion that adequate medical care is now beyond the means of all but the upper-income groups. On the contrary, any family which can afford a package of cigarettes a day, or a weekly movie, can afford the finest kind of prepaid medical and hospital protection. The cost is about the same.

THE FALLACY OF "NEEDLESS DEATHS"

The most serious misstatement in the President's message—and one which it is regrettable any President of the United States would have uttered—is the repetition of that now completely discredited statement that tens of thousands of persons die needlessly in this country, due to lack of medical care.

The President, in this instance, as in others, undoubtedly based his statement on the distorted report of the Federal Security Administrator, whose listing of "needless deaths" included 40,000 deaths from accidents and 115,000 from cancer and heart disease.

It is shocking that any Government department head would seek to impose on the credulity of the American people with such flagrant misrepresentations—and it is unfortunate, indeed, that the President of the United States should have repeated, even in part, the misinformation contained in this report.

AMERICAN PEOPLE ARE MEETING THE PROBLEM—THE AMERICAN WAY

There is a very real need in America for the budgeting of medical costs and American medicine is proud of the part it has played in building the voluntary health insurance systems to meet that need. There is no need, however, for compelling the American people to join a Government system. The voluntary way is the American way—and the people will resolve this problem, in a very short span of years, under the voluntary systems now available to them.

Mrs. EVANSON. From the past record the farmers conclude that if the AMA is against it, it must be good because when a bill eventually becomes law the AMA (from our past experience) will eventually endorse it, possibly to the extent of taking credit for the act. As an example I quote from a propaganda sheet written by Dr. Elmer Henderson, president, now president-elect, of the AMA:

> The doctors of America, in cooperation with the prepaid medical and hospital care plans and the many splendid voluntary health-insurance systems, have made great progress in achieving that objective—

the objective being adequate health services within reach of all people.

> American medicine is proud of the part it has played in building the voluntary health insurance to meet that need.

But we have not forgotten the old cry of socialism, communism, regimentation—when voluntary insurance was proposed to meet the need. Let us see how voluntary insurance is meeting the need. Less than 3 percent of the rural population are included in this "great achievement." The AMA may be proud of this achievement—we are not.

"Within reach of all people" does not make it available to all people. The statement that national health insurance is "the discredited system of decadent nations which are now living off the bounty of the American people" is a vicious unwarranted misstatement against the courageous thrifty people of the Scandinavian countries.

New Zealand and Australia, who are far from decadent, whose health standards are higher than those of the United States—and such devastated countries as Holland and Belgium who had national health insurance long before the Germans, and later the American bombers devastated those small countries—American bombers? Yes—with a promise to rebuild their cities. And the doctor has the effrontry to call them decadent countries living off the bounty of the American people—a most shameful below-the-belt statement from the president of a once highly respected American institution.

Dr. Henderson also states:

> President Truman makes the amazing assertion that adequate medical care is now beyond the means of all but the upper-income groups. On the contrary any family which can afford a package of cigarettes a day or a weekly movie can afford the finest kind of prepaid medical and hospital protection—the cost is the same.

I am thinking of the young mother who said, "We can't have any more babies—this baby cost us $384." Voluntary insurance paid $25 of that amount; or the mother of twins whose hospital bill for 8 days was $244.77, and by the way $90 for the babies for oxygen was spent for a week beyond this item of $244.77, and they received $56 through their voluntary insurance policy on the hospital bill. Is that Dr. Henderson's idea of the finest kind of prepaid hospital protection? His idea of great achievement? A package of cigarettes a day—he didn't say for how many years.

Dr. Henderson states further regarding the President's message on national health insurance—and all of this is, by the way, being quoted from this propaganda that is being spread out through our rural areas:

> The most serious misstatement in the President's message is the repetition of that now completely discredited statement that tens of thousands of persons die needlessly in this country due to lack of medical care. The President, in this instance as in others undoubtedly based his statement on the distorted report of the Federal Security Administration whose listing of needless deaths included 40,000 deaths from accidents and 115,000 from cancer and heart disease.

Dr. Henderson poo-poos the many, many deaths from accidents in rural areas because of the lack of doctors and hospital facilities to care for the injured. Farming is becoming highly mechanized—North Dakota is the most highly mechanized agricultural State in the Union, consequently we have a high rate of accidents and in many instances no doctors or hospitals to care for them.

This map that I have shows 26 counties out of 53 in North Dakota without hospitals—many people hesitate to put money into the building of a hospital when they are not sure they can afford to use it after it is built.

In the Slope country, if they are too badly injured to be taken by car to a hospital 80 miles away, over secondary roads, they must be taken on a stretcher by train 185 miles to Miles City, Mont., or 230 miles to Aberdeen, S. Dak., outside of the 180 miles over gravel roads, very bad roads.

Yes, many, too many, die needlessly from accident, Dr. Henderson. He scoffs at the statement that death from cancer and heart disease is needless. Yet Canada has cured an estimated 40 percent of their cancer patients because when a patient is suspected of having cancer—all costs are immediately taken over by the Government and the patient is given treatment by a specialist without cost to the individual—countless numbers are restored to good health.

Death from cancer needless? Yes. We also know that, if children were given proper health care and there was a preventative and contagious-disease control program available to all children, heart disease would not be the No. 1 cause of death among our people. Scarlet fever, bad tonsils, and adenoids, bad teeth—all these affect the heart.

Yes, we have 325,000 needless deaths each year, too many of them victims of an inadequate health program.

The AMA is proud of their record of 37 or 55 million under a very limited voluntary hospital program. They do not say how many of these dropped their insurance policy. Records show that there is a marked dropping of voluntary insurance after the third year. They do not give the figures of the millions that do not carry insurance. It is this group that we are concerned about. We often wonder how much money there would be for public schools if it was voluntary for people to pay the school tax—and would we be proud to say that 37,000,000 were getting an education but 80 or 100 million were not getting an education because they could not pay the tax. No, we cannot share the pride of Dr. Henderson and the AMA.

We want a strong America and we want a free America. We want an America whose people can walk upright, proud, that they are stockholders of a great democracy—stockholders because they are contributing to the general welfare of its citizens, not accepting charity offered begrudgingly in the Taft bill and the Hill bill—controlled and administered by organized medicine. Charity? Pauper's oath? We prefer sickness—death.

When will you who sit in power in Washington—you who represent us back home—when will you understand? What must we do to get you to see, to know the needs and the aspirations of we whom you represent? It is a travesty on American justice—on the rights of the people—that you even dare suggest that we submit to such indignity. Can't you see that we are trying to make health services available to millions who have never been able to afford medical care—that voluntary health insurance cannot reach? We want to eliminate in the services the 40-percent rejections, the 76-percent rejections. We want to cut down the billions spent for feeble-minded institutions, asylums, reform schools—all of whose inmates have handicaps, physical and mental.

How can any upstanding citizen representing a free people ask us to accept the humiliation of a means test that we and our children may get health care. Free people? A pauper's oath denies that freedom.

How long do you expect us to accept the philosophy that mothers shall be proud to raise their children to provide battalions for war and destruction and that we shall accept the pauper's oath if necessary in order to provide healthy specimens for your war machine? Seventy-six percent of our Government's income for war—pauper's oath for the pawns of this war machine.

Yes; we mothers and dads are angry. We still remember the hungry thirties—all too well. We remember the humiliation, the indignities, that people, good people, a proud people, were subjected to, to get food for their children. Surely that is not to become a part and parcel of the American way of life. We saw what it did to one generation. We will have no more of it.

How many of the rejections of our farm boys in the service are related to the lack of food in the thirties will never be accurately determined, but I well remember children coming to school day after day with lunch pails containing plain bread with black molasses, no butter, on their bread, no fruit—no other food—because their parents refused to accept charity and all the humiliation that went with it. I saw children's health being undermined because of an inadequate die, because they could not get health care.

There was one pitiful case for which we were able to get help, but it was rejected by the parents because it was charity, and we saw that child grow to manhood rejected for the armed services when his country needed him. Also rejected was the boy on the black-molasses diet. Is that economy? I call it a terrible waste of our greatest asset, human resources. A shameful waste of human resources. We the mothers challenge the AMA and their great achievements in voluntary health insurance. We challenge their broken promises, their delaying tactics, the hiring of professional blockers of progress with their phony propaganda and manufactured public sentiment.

The medical association seems to know what they don't want, but it seems to me they are very vague about what they do want. They don't want a national health-insurance program to provide for the health needs of people. What do they want? They say they want voluntary health insurance, yet they fight a national plan of voluntary health insurance. They keep telling us they are formulating a plan. We have waited long and patiently; we are still waiting, but not so patiently. Now, on the other hand, we know what we do not want and we know very clearly what we do want. We do not want needless suffering, needless crippling illnesses, needless deaths because of inadequate health care. Nor do we want the worry of finding the wherewithal to pay for health care if it is available. We don't want charity and a pauper's oath in order to get health care.

We do want our children, all of them—to have the right to good health as they have the right to an education, to an orderly system of government. We want every mother to have good prenatal care, hospital care in childbirth, and postnatal care for herself and child. This is one of our greatest needs in rural areas where over 50 percent of the babies in the United States are born.

We want adequate health services and hospital facilities available to all through a national plan of complete health insurance, not 10 percent parity of health offered us through the Taft bill and the Hill bill. We want local control of programs with lay representation. We want more research—more preventative work. We want more doctors, dentists, nurses, technicians.

We, the people, want to share the cost of providing good care to all regardless of their income and, lastly, we want the AMA to quit stalling and come forward with a sound plan to meet the medical needs of our people today, to quit dealing in generalities and deal realistically with the health problems of people. We do not want to stop the propaganda job of the AMA. They are doing a good job for us. They say that "without compulsion we have created the best medicine in the world." All right; now let's make it available, for that is the only reason for its creation.

We are happy that some of our Congressmen are presenting a plan that will eliminate the means test and recognize the fallacy of a flat fee that we have in voluntary insurance. However, as long as it is involuntary, it will not reach millions of our people, and the worry that we have is for the children who suffer thereby.

This quote from Human Conservation by the National Resources

Planning Board expresses the needs and goals we must reach to meet these needs:

> Health care organized to protect and care for all members of the family with a clear realization of how health and family life are inextricably related calls for an orchestration of medicine, psychiatry, dentistry, nursing, public health, social work, education, and recreation to foster saner, healthier living as well as to provide needed medical treatment and care for illness and disorders, and for the critical events of life. If the family is as important as is publicly proclaimed—and it is—then it merits more well-planned effectively administered guidance and coordinated assistance. For many of these advances, professional knowledge and skills, organized facilities and equipment must be provided by the community, since they are wholly beyond the resources of most families. The outline of a broad national policy of family-aid guidance, housing, nutritional, and health care can now be formulated. The adoption of any such policy for the family will be governed by the extent to which we recognize that family conservation and protection are no less legitimate public responsibilities than the Government aid and protection given for years to agriculture, business, and industry.
>
> Today we see that by building dams, reforesting the land. conserving the soil and otherwise husbanding our precious natural heritage, we can avoid the disastrous floods, the dust bowls, the soil erosion, and fire-blackened cut-over lands, So, equally are we realzing what human loss means and what is costs, not only in money but in needless suffering, misery, and unhappiness.
>
> We are ready for human conservation to replace the tremendous expenditures of time, energy, and funds now spent to patch up, repair, and barely keep alive the many victims of our present social economic life. Human conservation is an invitation to think and act as the custodians of the precious heritage of human life and fertility, the on-going stream of life moving toward the future now entrusted to our care.

The National Health Insurance and Public Health Act (S. 1679) provides no halfway plan, no piecemeal plan, but a plan for a total program of health for people. The Farmers Union is happy and proud to endorse S. 1679 and to actively participate in forwarding this program to give people the right to good health. We call on all men of good will who have a vision of our great potentialities to make S. 1679 a reality.

Senator MURRAY. Mrs. Evanson, I assume you have spent a great deal of time in the rural areas studying these problems that you have been discussing here.

Mrs. EVANSON. Yes, indeed.

Senator MURRAY. How many years have you been connected actively——

Mrs. EVANSON. I have lived all my life in rural areas. I taught in rural schools. After I was married, I contacted the Farmers Union. We lived on a farm.

It was there in the fall of 1933 that I became a local leader in the Farmers Union. Since then I have been very active. The reason I took to the Farmers Union program and took on the work of leadership was because in the rural schools I noticed particularly the lack of health care, the great need for something to be done about it, and the Farmers Union was the answer to that need, and it was on that basis that I joined the Farmers Union and became a leader in the work.

I was a local leader for several years, a county leader, and when we left the farm I was asked to take this State director's job, and health has been always the nearest to my heart, health and education of rural children, health because education means nothing unless they have health first, and I have seen the neglect in rural areas that is appalling.

Senator MURRAY. Well, thank you very much for your statement.

We will hear next from Lloyd C. Halvorson.

STATEMENT OF LLOYD C. HALVORSON, ECONOMIST, THE NATIONAL GRANGE

Mr. HALVORSON. I am Lloyd Halvorson, economist for the National Grange.

The health objective which the National Grange believes we should strive to attain was expressed at the 1947 annual session in the following language:

> Whereas sound health of the people is essential for national strength and social progress; and
>
> Whereas sound health is a humanitarian consideration: Therefore be it
>
> *Resolved*, That the National Grange adopt the following health objective:
>
> That rural people share fully in the benefits of modern medical science regardless of their economic status, race, or geographical location.

In order to attain this objective, the National Grange recommended the following specific steps:

> 1. Improved accessibility, availability, and quality of hospital and medical facilities in rural areas.
> 2. An increased number of well-trained physicians with proper distribution in rural areas.
> 3. A medical cost payment system which will enable all people to secure modern medical care without undue burden.
> 4. A rural citizenry informed as to what constitutes adequate medical care and its importance, and a citizenry informed as to how it can best be secured for all.
> 5. Adequate public-health services.
> 6. Increased research in the various fields of health.

We are glad to see legislation which is seeking to put into effect some of the steps which the Grange favors.

PERSONNEL IN THE HEALTH PROFESSION

The National Grange, at its 1947 annual session, adopted the following resolution on medical personnel:

> Some rural communities need doctors, dentists, and nurses.
>
> Recommendation: Local communities should make their needs known to medical, dental, and nursing societies and take steps to induce doctors and nurses to come. If medical services are not available locally, the community should consider the establishment of ambulance service.
>
> More doctors, dentists, and nurses need to be trained.
>
> Recommendation: Adequate medical- and dental-school facilities should be provided by the colleges. Monopolistic abuse in determination of medical- and dental-school enrollment should be prevented. Medical- and dental-school scholarships should be provided young people wishing to practice in rural areas. Young women should be encouraged to take up nursing, and training of nurses should include some experience in rural hospitals.
>
> Modern medical and dental equipment is needed to attract medical and dental personnel and to enable them to provide good medical care.
>
> Recommendation: Health centers and hospitals can be brought to rural areas under the Federal Hospital Survey and Construction Act and local communities can otherwise help equip a doctor's or dentist's office. Action along these lines should be taken in areas where the need exists.

This resolution was reaffirmed at the last (1948) annual session of the National Grange.

Rural areas suffer more than other areas from the scarcity of medical personnel. This is a fact supported by experiences of farm people and by statistical studies. In "Better Health for Rural America," published in 1945 by the United States Department of Agriculture, we find the statement that in the 1,000 most rural countries, there was only 1 doctor for every 1,700 people while in the big city areas there was 1 doctor to every 650 people. In addition we know, and statistics show, that the country doctors tend to be well along in years. In rural areas, there was only 1 dentist to every 4,200 people while in the cities there was a dentist for every 1,400 people. In many rural hospitals, there is not even one graduate nurse.

With the recent spell of agricultural prosperity, the income of farm people in many areas has come up close to urban income, and farm people are demanding more medical attention. To meet this need adequately, more well-trained doctors are needed. Last year we ran a small note in our Deputy Newsletter stating that a young doctor had written to us concerning a place to practice. We received many prompt inquiries telling of the need for a doctor in the community. Usually the situation is that the old doctor had made a good income but had died or retired.

There are many young farm boys and girls who are very intelligent, of good character, and of pleasing personality who would like to study to become doctors, dentists, nurses, and so on, but who cannot afford the cost of schooling. We, as a farm organization, would like to see farm boys and girls have a chance to develop their talents to the highest use; and, also, we know that after these farm boys and girls are trained, many of them would return to rural communities and make a real contribution to the health and happiness of the rural people.

You will note that the resolutions relating to medical personnel adopted by the National Grange are rather modest when compared with the plan of scholarships and subsidy contemplated by title I of S. 1679. Our resolutions say nothing concerning Federal action, and for the most part, our resolutions contemplated State and local action and private action. However, the National Grange has favored Federal aid for primary and secondary education and such Federal aid as has been given vocational agricultural training in high schools, and such Federal aid as the land grant colleges have received.

We are not in a position to evaluate the need for large-scale subsidization of medical schools. However, it may well be, we realize, that in the States with limited resources, the need for Federal aid to expand medical-school facilities may be as great as the need for Federal aid to primary and secondary schools. In general, the Grange has shown most interest in the use of scholarships as a way of increasing the number of medical, dental, and nursing school graduates. This is not only because of the fact that only a few rural boys and girls can afford to go to medical school, but also because it seems to us to offer a good way of maintaining and securing the best type of individual for the practice of medicine.

The Grange believes it is very proper for the citizenry to take what action it deems proper to increase the number of doctors. If it were not for our State-supported medical schools, the number of doctors would quite certainly be smaller than it is today, and the fee-for-service schedule would quite certainly be higher. From the standpoint of the people, it is probably good economy to increase the number of doctors, even though enlarged medical schools and scholarships would cost money. The need for more doctors is so great that it is quite certain that without a stepped-up medical-school program, medical-service needs would not be met, and the result could easily be an increase in the fee-for-service schedule. This would certainly discourage people from getting the medical attention their health requires.

The Grange wants to maintain high-quality medical care and for this reason would oppose any lowering of standards in order to graduate more doctors. With the use of scholarship grants to well-qualified students, we are confident that the present standards can be maintained or even raised at the same time that we graduate more doctors.

While the Grange favors Federal aid for schools, it strongly opposes Federal control and would reject Federal aid if it meant Federal control. In this connection, we are glad to find that section 382 specifically prohibits any Federal control of medical education.

Senator MURRAY. Mr. Halvorson, we are a little pressed for time. If you care to, you can summarize some parts of your statement. Your entire statement will be printed in the record. If you want to point out some sections that you wish to emphasize, you may do so.

Mr. HALVORSON. I will do that. In medical research, we feel that it is the place for Government action. A lot of research brings dividends to the corporations but not to the people.

In hospital construction, there is a little argument over that. We favor increasing the funds. We think the aid to the States should be in accordance with the ability of the State, that is, whether it is 33 percent or 66 percent. We like the provision of giving the respective States some discretion within the State as to whether one community should have 30 percent or 60 percent. We like the provision that will give more authority for building health centers in rural areas.

Now, this title that has to do with special aid for rural and other shortage areas, we feel that in some areas it is necessary to give the doctor a grant to get him to locate in a rural area. In many places where the farm income has been so low that you cannot attract a doctor there even to take care of the emergency needs of the people—just as we would not send a lot of soldiers to some place without some medical attention, I think we ought to give the same consideration to our own people who are farming.

We endorse the provision having to do with the cooperatives. The Grange has favored the cooperative approach to problems for a long time. We were quite instrumental in getting the Federal land bank set-up, for getting farmers credit, production credit, REA, and so on.

We notice this section of aid to cooperatives is on an experimental basis. We think it should be put on a rather permanent basis like REA rather than something that will be just temporary. We feel it is to be in an experimental stage at the beginning, but certainly, if it is to be taken up at all, it should be put on a more permanent basis.

Concerning the local public-health service, the Grange has favored Federal grants in aid to expand that service. The farm people are becoming increasingly aware of the need for public-health services. They found out that the communicable diseases are taking a heavier toll in the rural areas than in the city areas, and certainly that should not be with the open country.

Therefore, they realize the need for better sanitation, quarantine, and medical examination and advice to people.

Concerning maternal and child-welfare and crippled-child services, the Grange has taken no specific action, but I know that some of our State masses that I have been in contact with feel that it is very valuable work that has been done and favor it.

Coming to the problem of medical care, in an advanced society most people would not like to see an individual suffer or die if medical knowledge and facilities could prevent it, even if the individual could not pay for it himself. Going even further, we do not like to see people ruined financially by heavy unexpected medical bills. To the extent possible, the people should meet these problems on a local and State basis.

The Grange has never taken any specific action on compulsory health insurance. We have had resolutions adopted against socialized medicine, but some of our members, I believe I can say, could not consider public-health insurance to be socialized medicine, but others do, so it has been impossible for me to determine just what the position of the Grange is from the resolution against socialized medicine. Although we did testify several years ago against a national compulsory health-insurance plan, I do feel that there are some of our people that are strongly against it; I know for sure. There are some, however, that are very open-minded on it—and I think, in general, our people are quite open-minded on the subject—but the resolutions that have been adopted in the past seem to come very closely in line with S. 1970, the bill that Senator Flanders was explaining this morning.

We have a resolution against the means test, and I would like to read a short statement from our resolution that was adopted in 1947, though it was quite a while ago:

> Means tests for those unable to meet the cost of adequate medical care should be avoided if at all possible and, instead, a reasonable payment should be required of every individual or family in view of their income status and benefits received.

We have reconciled also in our health program that there will need to be some way to provide adequate medical care to the low-income people who cannot afford it on their own, so the bill that Senator Flanders has introduced, and others, seems to come very closely in line with our thinking.

We like the voluntary idea. Farm people that I know and those in the Grange seem to be opposed to anything compulsory—they do not like the idea of compulsion, but we feel that something like health insurance is not where you are jeopardizing the public in general by what you are doing.

Senator MURRAY. Of course, our national educational system is a compulsory system.

Mr. HALVORSON. Yes, but it is essential there for the preservation of democracy, because you have got to have educated citizens to vote properly, and so on.

Senator MURRAY. Well, the preservation of the health of the people is equally important, is it not?

Do you not think that if the health of a great mass of the population was neglected to such a degree that they were in a dangerous condition, that that would be bad for the safety and security of the country?

Mr. HALVORSON. Well, it would be bad from the standpoint of national defense, but we have democracy—we have had democracy for many years without any comprehensive health program such as is contemplated.

Senator MURRAY. That is right, but when we come to selecting soldiers for fighting in Europe, we find quite a high percentage of rejections.

Mr. HALVORSON. That is right.

We feel that we should do what we can to avoid that. We think something like S. 1970 would go a good ways, but for one thing you cannot make health care compulsory. You cannot compel someone to go to a doctor if he does not want to go. I do not believe you can do that under our form of government. There is a slight difference between health and education, I think, as far as Government participation is concerned.

Now, another point that I would like to bring out in regard to compulsory health insurance for farm people is that the old-age insurance has not yet been extended to farm people, and one of the biggest reasons for it is that the problem of administration has been feared as being so great that the system will break down.

In other words, to exact a tax from farmers, the farmer will have to compute his net income, and very few farmers know what their net income is, and many of them never calculate it, and the problem of collecting the social-security tax from farmers, or a compulsory health insurance tax, will certainly be very great.

There is another matter I might bring up in connection with that. The compulsory health insurance for the wage earner in the city means that he only pays half of this cost, but to the farmer who is probably in a poorer financial condition than a lot of these industrial workers, there is no employer; so he would have to pay the employee part of the employer part, and the burden on farm people would be quite heavy in many cases.

Senator MURRAY. Of course, it all depends upon the income of the farmer. If we are able to maintain good prices for farm products, they are in a better position than men working in a factory, do you not think so?

Mr. HALVORSON. Well, the income of farm people is not yet up to the income of the industrial worker.

Senator MURRAY. I beg your pardon?

Mr. HALVORSON. The income of the farm worker or of the farm family is not yet up to the income of the industrial worker or industrial family.

Senator MURRAY. It is not up to the income of the city factory worker?

Mr. HALVORSON. That is right.

Senator MURRAY. That is the farm laborer, you mean?

Mr. HALVORSON. No, I mean the farm operator, too.

The per capita income on farms last year was something over $900 only, and I think in the city was over $1,400.

Senator Murray. When you go into statistics like that, it does appear that your argument has some merit to it, but also if you go on the basis of statistics, there are certain large sections of the workers in the Nation that get a very low income.

Of course, if you average it up, the income of the city worker is probably much better than on the farm, but there are 30 percent of the people in the United States who earn less than $2,000 a year.

Mr. Halvorson. I would say that on farms probably 50 percent of the farm operators do not have a net income of $2,000 a year.

Senator Murray. Fifty percent of the farmers of the United States?

Mr. Halvorson. I am sure that that is true of the net income. Even on gross income, my recollection offhand is that one-third of the farm families do not have a gross income of $2,000 a year.

Senator Murray. You may proceed with your testimony.

Mr. Halvorson. I believe that that is all I will need to mention outside of the written statement here. I would like to point out some of the reasons that we have not favored compulsory health insurance, and one is we are afraid the abuse by doctors and patients could skyrocket the cost of medical care. It must also be recognized that if a rich family can use $400 worth of medical care in a year, so can a poor man under compulsory health insurance. Consequently, the cost could be very great.

Now, the Grange has feared a Federal bureaucracy with the resultant cost. We also fear that there will be some political interference with the practices of medicine. It is hard to prove one way or another, but we do fear that if a patient did not like the number of days a doctor had allowed him in the hospital, he might write to his Congressman or his Senator, and the Senator or Congressman would write the doctor and say "Why did you not let this man stay a little longer? He needed to stay." You get politics into it that way, we fear.

I believe that concludes my oral statement.

Senator Murray. I can understand how there can be a great deal of confusion with reference to the seventh title of our bill, S. 1769, because there has been a great deal of misrepresentation about that title in the bill, and a great deal of confusion, misunderstanding has developed in the country, but aside from that seventh title of our bill, the Grange favors the other provisions of the bill with reference to expansion of medical education and hospital expansion and research and the other sections?

Mr. Halvorson. Yes, we do. I believe in that section having to do with increasing the personnel, we feel that probably should be on a State program. As I understand it now, the Federal Government will make grants directly to the medical school rather than to the State program, and we feel possibly there should be set up a State program with Federal grants in aid to that State program, so that that might be one slight difference, but we are in accord with the objectives.

Senator Murray. And with reference to the seventh title, the one with reference to national health insurance, you think that requires more study, more consideration?

Mr. Halvorson. Yes. We feel that the Flanders bill, S. 1970, has a lot of possibilities and could be developed to be quite in accord with our views concerning adequate medical care.

Senator MURRAY. Have you made a very careful study of that bill?

Mr. HALVORSON. No; not too carefully. I read it over.

Senator MURRAY. When did you see the bill?

Mr. HALVORSON. It must have been about a week ago that we received it.

Senator MURRAY. The first time I saw it was this morning, so you had a week's advance start on me, but I imagine that it will be given very careful study now, after hearing this testimony this morning, but you do believe, though, that the other provisions of S. 1769 are satisfactory and along the right line with reference to medical education?

Mr. HALVORSON. Yes, the Grange never took any specific action on maternal and child welfare, but I think that our people are in accord from the few comments that I have had.

There is one thing more I just remembered that I would like to bring out. I believe S. 1581 has a section on school health services, and we certainly believe in any bill to provide school health services, and we have a specific resolution on that which I will not read. It is to the effect that we are very much for it.

Senator MURRAY. You realize that we have already passed a bill dealing with rural health services, and have taken it out of the education bill entirely?

Mr. HALVORSON. No; I did not know that.

Senator MURRAY. We have passed a bill in the Senate which provides for rural health services and health services in general.

Mr. HALVORSON. I knew there was another bill, but I did not know it had gotten that far along.

Senator MURRAY. Thank you very much for your testimony.

Your whole prepared statement will be included in the record at this point.

(The prepared statement submitted by Mr. Halvorson is as follows:)

STATEMENT OF LLOYD C. HALVORSON, ECONOMIST, THE NATIONAL GRANGE

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PERSONNEL IN THE HEALTH PROFESSION

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"Recommendation: Local communities should make their needs known to medical, dental and nursing societies and take steps to induce doctors and nurses to come. If medical services are not available locally, the community should consider the establishment of ambulance service.

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The Grange believes it is very proper for the citizenry to take what action it deems proper to increase the number of doctors. If it were not for our State-supported medical schools, the number of doctors would quite certainly be smaller than it is today, and the fee-for-service schedule would quite certainly be higher. From the standpoint of the people, it is probably good economy to increase the number of doctors, even though enlarged medical schools and scholarships would cost money. The need for more doctors is so great that it is quite certain that without a stepped-up medical-school program medical-service needs would not be met, and the result could easily be an increase in the fee-for-service schedule. This would certainly discourage people from getting the medical attention their health requires.

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While the Grange favors Federal aid for schools, it strongly opposes Federal control and would reject Federal aid if it meant Federal control. In this connection, we are glad to find that section 382 specifically prohibits any Federal control of medical education.

MEDICAL RESEARCH

At its 1947 annual session, the National Grange took the following action on medical research:

"Problems of medical and dental research: Many diseases could be conquered by research.

"Recommendation: Increased funds on the Federal, State, and local levels to make more research possible should be urged."

At its 1948 annual session, the National Grange reaffirmed this action.

The tremendous gains made in the field of medicine attest the public value of research, but we must recognize that much-needed research holds no promise of monetary gain. In such circumstances, unless someone provides the money, the research is not carried out. The National Grange has for many years believed that the promotion and the carrying on of research is a proper and essential function of the Federal Government. We advocate sufficient Government support to keep this Nation in the front rank in conquering diseases which still unrelentingly plague mankind.

HOSPITAL CONSTRUCTION

The National Grange has supported the Federal hospital survey and construction program from the beginning when it was first known as S. 191, the Hill-Burton bill. The reasons for which we supported the bill then, apply with equal force today. Much needs still be done to improve the health facilities of the Nation, and especially the facilities in rural areas.

The facilities in rural areas have not only failed in many instances to keep up with advances in medical science but are also inadequate from the standpoint of number of beds and accessibility.

Good health is a matter of national concern. Physical fitness and endurance of the people is as important to national defense as airplanes and munitions. Also, we know that a person with impaired health can move about and thus become a public charge in a different State from the one in which his health was neglected.

Hospital facilities in many rural areas are either lacking entirely or are very inadequate. Farm people know this from experience and statistics bear it out. A United States Department of Agriculture publication entitled, "Better Health for Rural America" (1945), stated:

"Widespread rural areas are very poorly served by hospital facilities. Over 1,250 of the 3,070 counties of the Nation are without a single satisfactory general hospital. Over 700 of these counties have populations exceeding 10,000 people.

"To serve people properly, there ought to be about 4.5 general hospital beds for every 1,000 persons in the State. Quite a few cases of illness among rural people, however, are and should be referred to city hospitals for care. While in the cities, therefore, 5 or more beds per 1,000 persons may be necessary, in the rural areas 3.5 or 4 general beds per 1,000 are probably adequate. The fact is that today most rural areas do not have even 2.5 beds per 1,000."

The State of New York is not by any means the most lacking of the various States in rural hospital facilities. However, we happen to have a copy of a letter dated August 21, 1947, which John J. Bourke, executive director of the New York

Hospital Survey, sent to Henry D. Sherwood, master of the New York Grange. The following excerpt explains in part the hospital situation in that State:

"As I mentioned above, our regional councils have appraised all of the 582 hospitals in the State from the standpoint of suitability, safety, and adequacy. In carrying out this type of work, one is conscious of the present deficiencies in rural hospital care. For example, there are a number of rural counties that have no adequate hospital facilities. In the main, rural hospitals have been established as private profit-making enterprises by an individual or group and, in some instances, by physicians in order to have the tools with which to work. For the most part, these hospitals are in converted frame dwellings which present definite fire hazards. They do not have the equipment, physical plant arrangement, or balanced medical staff which are indicated in modern medical practice, and in the main they operate as isolated institutions with very little working relationship with larger modern and adequately staffed urban hospitals. When one analyzes the flow of patients under such situations, we find that a large proportion of those needing hospital care, who have the liberal funds to go to the larger urban hospitals, do so. In one rural county 50 percent of all the persons requiring hospital care during 1945 left the county, traveling from 35 to 60 or more miles to secure their hospital services. This county has six converted frame dwellings serving as hospitals with capacities from 8 to 32 beds. Under this type of situation, it is difficult to support local medical service, and I believe that the provision of a fewer number of modern larger facilities would result in more physicians practicing in the area, and the people best able to support the services would do so. As a minimum estimate, up-State New York will require about $80,000,000 of new modern hospital construction. Under the Federal Hospital Survey and Construction Act, New York State will receive less than $15,000,000 in Federal grants over the next 5 years. In other words, only $45,000,000 of hospital construction of all types can be aided under this program. The financial condition of hospitals at the present time is not good, and I believe every effort should be made to encourage Congress to liberalize the appropriations for this well-accepted and necessary program. One of the most difficult tasks for the Commission and its State advisory council will be the allocation of the limited Federal funds since the number of applicants will greatly exceed the number that can be aided. I am forwarding a copy of the recommendations for chronic disease hospital care, and any support that the Grange can give to this program should be very worth while."

We feel it is very appropriate for the Hospital Survey and Construction Act to specify that grants-in-aid be allocated on the basis of need with added priority to rural areas.

Ideally, every local community and every State should provide itself with adequate hospital facilities, but we know that for some reason this has not been done. A major reason for this is that some local communities and States lack the necessary resources. There is a tremendous variation in the per capita income and taxable resources among the States and within the States.

We feel that Federal aid to hospital construction is an excellent way for the Federal Government to improve health conditions. It does not invoke any great danger to our American way of life. In other words, it avoids such problems as means tests, and there is little said of the danger of Federal or political control over economic activity or political thinking and behavior.

Grange members all over the Nation have participated in the Federal hospital program at all levels of activity. So far as I can tell, our members have looked upon the program as not only desirable but nearly as indispensable if they are ever to get adequate hospital facilities. This, I believe, is reflected in the following resolution which was adopted by the delegate body of the National Grange last November:

"The program under the Hospital Survey and Construction Act should be continued and extended under a policy of flexibility permitting adaptation as may be required to meet changing needs. The present authorization of $75,000,000 per year should be increased in view of the urgent needs for the establishment of additional hospital beds and clinics and health centers in many areas of the country."

In addition to this resolution, a number of other resolutions were adopted that relate to some degree to this bill. They are as follows:

1. "The program under Public Law 725 and the hospital program of the Veterans' Administration should be closely integrated in the interest of good planning."—Adopted.
2. "Hospitals within service areas should be functionally or organically asso-

ciated with one another so that the patient may benefit from the resources of all."

3. "Governmental agencies having assumed responsibility for hospital care for patients and nongovernmental agencies purchasing hospital care should pay the established rate for such care."—Adopted.

4. "Hospitals, health departments, and all other health agencies should seek every method for coordinating their efforts and integrating their functions in the interests of greater efficiency and services to the patient."—Adopted.

5. "Diagnostic clinics, out-patient services, and home medical care and allied programs should be developed more extensively in extending health services for all."—Adopted.

6. "Hospitals should intensify and extend their basic activities in research and education."—Adopted.

7."Preventive medical and dental service and public-health education should be carried out more widely as regular functions of the modern hospital."—Adopted.

8. "Insofar as possible the general hospital should provide facilities for the care of all types of illness, with increased attention to the diagnosis and treatment of the patient with long-term illness."—Adopted.

9. "The pressing need for additional facilities for the care of the mentally ill and chronic diseases in general hospitals makes it necessary that special emphasis be given to this problem in the original State hospital plans and any revision of these plans under Public Law 725. A careful study to develop recommended standards is needed in this area for the guidance of State organizations under this act."—Adopted.

10. "To develop and adequately meet good standards of patient care, it is recommended that all hospitals, nursing homes, and other facilities for the care of the sick should meet at least minimum standards through the mechanism of licensure."—Adopted.

11. "The control of local facilities should be by the people in that locality on a cooperative or community basis, where possible with an elected board of directors, representative of lay and professional groups."—Adopted.

12. "Lay and professional organizations and governmental agencies should join in conducting a health education program and in developing plans for adequate facilities and health services which will include well-coordinated and highly integrated networks of mobile units, clinics, community hospitals, district hospitals, regional hospitals, and great medical centers."—Adopted.

13. "That each State agency operating under the Hospital Survey and Construction Act consider carefully the advisability of organizing a rural hospital subcommittee having representation from the major general farm organizations within the State and from the State land-grant college, to advise the State concerning matters of importance in rural areas."

Our health program covers a number of additional points which I will not take the time or space to cover here. I should mention, however, that we are very much behind group hospitalization plans and health coöperatives. They are quite an essential complement, we feel, to the hospital construction program.

In the previous year, the delegate body adopted a resolution instructing the National Grange to support appropriations for the hospital program in line with the authorization.

We believe that it is desirable to vary the Federal share of the construction cost from State to State as some States are less able to pay for hospitals than others. Also, it seems desirable to us to give the States authority within a maximum and minimum to vary the Federal share as provided in title III of S. 1679. We feel it is important that the Federal share not be so high as to stop supplementary State aid programs.

From what we understand about "coordinated use of hospital facilities" it means that all the medical equipment and skill in the whole hospital area will stand ready to render the best possible aid to a patient. In other words, not only the limited facilities of the local hospital will be readily available in case of need, but rather all the facilities and skill in the hospital area. In addition, we understand that under a coordinated hospital program it may be possible to bring more interns and doctors of different skills into rural areas. Because of this we favor section 5 of S. 614 which provides for studies and demonstrations in coordinated use of hospital facilities.

We note that section 309 (a) of title III, S. 1679, broadens the definition of a health center to include facilities for group practice of medicine and dentistry (or both) by or for a cooperative or other nonprofit cooperation. Many rural communities that cannot justify a hospital need some sort of health facilities. In some areas our members have been active in forming cooperative health clinics to meet their local needs. We feel it is quite appropriate that they get some Federal assistance even if they are not in a position to build something as large as a hospital.

SPECIAL AID FOR RURAL AND OTHER SHORTAGE AREAS

It is true that in some areas the income of the people has been so low that they have sought medical care only for acute emergencies. Such areas frequently cannot attract medical personnel and so the people in the areas are completely without reasonably accessible medical care. In some areas, distance rather than inadequate income may be the cause of medical care being so far away that the health and lives of people are in jeopardy.

We also know that medical personnel is reluctant to locate in rural areas, especially the rather isolated rural areas. While we hope that much will be attained by stepping up the number of medical and nursing school graduates, we believe that for some areas special incentives and assistance is needed.

Demand for medical attention increases quite rapidly with increased income, especially if there is a backlog of medical needs (such as operations) but unfortunately the supply of medical personnel does not increase very fast in the rural areas. In many cases, we believe all that is needed is something to induce a doctor to go to a rural area and after that things will work out by themselves. One reason for the difficulty of getting doctors into rural areas is that a relatively small proportion of the medical-school graduates are country boys and girls.

From our contacts with people who study health problems, we believe the consensus is that under the present system of medical care the distribution of medical personnel is probably a more important problem than the problem of over-all numbers, and also that increasing the number of medical- and nursing-school graduates will not by itself provide rural areas with enough medical personnel.

For these reasons, we favor loans and grants to induce medical personnel to locate in shortage areas. We also favor grants to aid in maintenance and operation of medical facilities such as local facilities for group practice, health centers, clinics, and hospitals. We believe that loans and grants for facilities will help bring medical personnel to shortage areas.

We believe that in programs to improve rural health the local people have the major responsibility, and that a health program should not be served to them from Washington while they are sitting in their chairs. Local people and local and State governments should be expected to put forth all the money and effort that is reasonably possible. For this reason, we believe that special aids to rural and other shortage areas should be set up as a State program with grants in aid from the Federal Government on a matching basis according to the financial ability of the State.

The Grange is an old advocate of the cooperative approach to solution of problems. The Grange has always believed that when a problem arises that demands solution that the Government should help people helf themselves rather than just taking the whole problem over itself. This is not only more practical and economical, but also in line with our philosophy of limited government and the philosophy that it is bad for citizenship to turn all our problems over to an "all-knowing" Government.

In past years, the Grange strongly favored the Federal land banks, the banks for cooperation, the production-credit system, and the REA as a method of helping farmers solve their own problems.

Now in the field of health, we believe that a program of loans and technical assistance to cooperative and State institutions such as we had to attain rural electrification could do must to attain our health objectives. Inasmuch as health care is a necessity, we believe that because some people cannot afford the full cost of medical care some grants to such agencies would be needed in order to help them care for such indigents. In the beginning, grants will be especially important because it will take some time to get the health cooperatives on the soundest possible basis and established.

We believe that the cooperative type of organization is well suited to medical care. In the first place, it brings about a good change in the organization of medical services. By use of adminitrative and auxiliary personnel, efficient use is made of the doctor's special skills.

It was found by Group Health, a health cooperative here in town, that medical services obtained by members would have cost them two and even three times as much if they had paid the prevailing fees for the services performed. Cooperative medicine also provides group practice, and this is important in these days of more complicated medicine and specialization. Cooperative medicine spreads the cost and is a form of health insurance. Also cooperatives provide comprehensive medical care and urge their members to have health check-ups. Because there is no financial determent to physical check-ups, people go to the doctor before they are really sick and thus cooperative medicine is really preventive medicine as opposed to emergency medical care.

We would like to see loans and technical assistance to health cooperatives put on a permanent basis like REA, but an experimental basis might be all right for the time being.

LOCAL PUBLIC HEALTH SERVICE

In 1947 the National Grange took the following action in regard to local public health departments:

"1. A third of the population of the United States, particularly in rural areas, is without an organized local health department directed by a full-time health officer.

"2. Twenty thousand of thirty-eight thousand different local governmental jurisdictions and seventy thousand of one hundred and eight thousand school districts are each attempting to operate their own health services.

"3. Such small units of government cannot expect to have enough tax money to attract the necessary trained workers to carry out a public health service to which the people are entitled: Therefore be it

"*Resolved*, That we favor:

"1. The enactment of State laws authorizing the creation of county-wide, city-county, or multicounty units of health jurisdiction.

"2. The employment of professionally qualified full-time health officers at appropriate salaries.

"3. Requirement by law that health departments carry on certain essential standard activities."

And also:

"1. Many rural counties are too small to be able to support a well-equipped and adequately staffed health unit.

"Recommendation: State legislatures may need to pass a law enabling the establishment of county, city-county, and multicounty health units which would be large enough to hire full-time personnel.

"2. Many rural communities do not have the protection and services of a public health unit.

"Recommendation: Rural people should seek to establish for their communities adequate public health services. The annual costs would be somewhat in excess of $1 per person under present conditions.

"3. Some communities cannot afford public health services, and this may be a hazard to other communities.

"Recommendation: Already the Federal and State Governments are providing rural counties with financial aid, but some expansion in the aid may be needed to do an adequate job. The National Grange should support legislation to meet this need.

"4. Preventing the spread of disease is still a major aspect of public health. However, with the increase in degenerative diseases, preventive medicine may need to give more emphasis to detection of these diseases.

"Recommendation: Laboratory tests and X-rays probably should be made a public health function. Increased Federal and State aid may be needed to enable local communities to do this. Legislation to achieve this should be supported."

These actions were reaffirmed by the National Grange session at its last annual session (November 1948).

Farm people are becoming increasingly aware of the need for public-health services. They have learned that the large, congested cities, where diseases at one time took a heavy toll, have now about conquered the communicable diseases. They are shocked to learn that the communicable and preventable diseases are taking a higher toll in the country than in the city. They see how a good public-health department can help guard the health and lives of children and mothers in the community; they are concerned with sanitation in parks, public eating places, the community generally; and they are becoming increasingly concerned with good water and sewage disposal in their own homes. They want to stamp out certain diseases; they want a good quarantine system; they want immunization programs; they want education; and they want somebody fighting disease and ready to stop outbreaks of disease whenever and wherever it occurs.

Public-health services has long been recognized as a type of function that naturally falls upon Government and as a highly desirable form of service that will safeguard the health of all. We believe that responsibility for public-health service is primarily a matter for local government, but we also recognize that disease knows no boundaries and that the State and Federal Governments have some responsibility. Unfortunately some local areas and States do not have enough resources to fully meet their responsibility to the public health. For this reason, we favor a grant-in-aid program to overcome the financial obstacle. As far as the Federal grant-in-aid program is concerned, we believe it quite appropriate that the States be required to match every Federal dollar with $2 on the average, but with variation among the States according to resource and need.

We hope that this Congress will pass a bill providing for grants in aid for expanded public-health services and more and better local public-health units.

MATERNAL AND CHILD WELFARE AND CRIPPLED CHILD SERVICES

The National Grange has taken no position on this subject though I have heard some favorable comments on these services.

PROBLEM OF COST OF MEDICAL CARE

In an advanced society most people would not like to see an individual suffer or die if medical knowledge and facilities could prevent it, even if the individual could not pay for it himself. Going even further, we do not like to see people ruined financially by heavy unexpected medical bills, to the extent possible the people should meet these problems on a local and State basis.

The Grange has considered the problem of medical cost and has made the following recommendation:

"1. Many farm families cannot afford adequate medical and dental care.

"Recommendation: Some farm families not now getting adequate medical and dental care could afford it through participation in group hospitalization and surgical-care plans, Grange health cooperatives providing comprehensive medical care have been even more successful in providing medical care at a figure many farm people can afford. The National Grange should strongly urge and cooperate in the development of cooperative hospitals and prepaid group hospitalization and medical care plans.

"2. Public and private funds will be needed to supplement the medical and dental budget of low-income families, even to make participation in group plans possible.

"Recommendation: The Grange should favor the use of Federal, State, and local funds, alone or in combination, to supplement the medical and dental payment of low-income families. The Grange should indicate principles to be followed in any such program."

The Grange has also set up some principles which we consider quite important in any public program for supplementing medical budgets. They are:

"Certain principles need to be established for purposes of health programs and health legislation.

"Recommendation: We urge adoption of the following principles:

"1. Every individual should put forth a reasonable effort to meet his own health needs either on an individual or group participation basis.

"2. Outlay of public funds should be kept as low as is consistent with the attainment of our objective.

"3. Local control and administration should be maintained to the full extent feasible.

"4. Means tests for those unable to meet the cost of adequate medical care should be avoided if at all possible, and instead a reasonable payment should be required of every individual or family in view of their income status and benefits received.

"5. Medical payment plans should be primarily controlled by the consumers or patients."

We would be very opposed to any means tests that causes public embarrassment. Mary hard-working, thrifty, and respectable people need help in meeting medical costs and the embarrassment of being marked as indigent would deter many people from medical care they urgently need. It would be much better to have a voluntary prepayment health insurance or service plan with rates based on the family's income and to some extent size with a subsidy to the plan by Government.

While the National Grange has not acted on S. 1970, it appears to me to come very much in line with the thinking of the Grange as to how the problem of medical costs can be met on the most economical and socially desirable basis.

We have considered S. 1106 and agree with the objective of trying to make the best in drugs available to people who often cannot afford them because of their high price. We believe in having State plans with Federal grants-in-aid on a matching basis. I believe that more comprehensive health legislation such as S. 1970 would be preferred by the Grange.

The National Grange has adopted resolutions opposing socialized medicine. To many members this means opposition to compulsory health insurance though not to all. Because farm people are not as yet covered by old age and survivors' insurance, it might not be realistic to seriously consider compulsory health insurance for farm people until the administration of old age and survivors' insurance has been tried.

As we see it, compulsory health insurance probably has some serious shortcomings. Abuse by doctors and patients could skyrocket the cost of medical care. It must also be recognized that if a rich family can use $400 worth of medical care in a year, so can a poor man under compulsory health insurance.

We fear that politics might get into compulsory health insurance, and this could easily demoralize patients and especially medical personnel. This would result in lower quality medical care within a short time.

The idea of a large Federal bureaucracy with the resultant cost also causes us to question compulsory health insurance. To us it appears that voluntary plans provided with some subsidy to supplement the contribution of low income families is a better way.

The National Grange at its last annual session took the following action regarding compulsory health insurance.

"Whereas, voluntary health plans are making rapid progress and these plans are generally run efficiently and to the satisfacton of members: Therefore, be it

"*Resolved* That people with comprehensive voluntary health service be exempted from any plan for compulsory health insurance should such health program be established."

This resolution is self-explanatory, and I might add that if people could choose between voluntary plans and Government insurance, I doubt if the Grange would have any serious objection to Government health insurance.

Further resolutions adopted by the National Grange at its last annual session which pertains to our health problems are quoted below.

1. "That adequate medical service for the prevention of illness, the care and relief of sickness and the promotion of a high level of physical and mental health should be available to all without regard to race, color, creed, residence or economic status.

2. "That the principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barriers to adequate medical services and avoid the indignities of a means test.

3. "That health insurance should be accompanied by such use of tax funds as may be required to:

"(*a*) Furnish services which are public responsibilities.

"(*b*) Supplement health insurance as necessary to provide adequate services for the whole population.

4. "That voluntary prepayment group health plans organized on a community or collective-bargaining level, embodying group practice and providing comprehensive service offer to their members the best modern medical care and are the best available means at this time of bringing about improved distribution of medical care in rural areas and should therefore be encouraged.

5. "That the people have the right to establish voluntary insurance plans on a cooperative basis and legal restrictions upon such right, now existing in a number of States, should be removed.

6. "That high standards of service, efficient administration and reasonable costs require:

"(*a*) Coordination of the services of physicians, hospitals, and other health agencies in all phases of prevention, diagnosis and treatment.

"(*b*) Efficient cooperation between the providers and the consumers of such services under the general principle that the responsibility for general policies, finances and administration should rest preponderantly upon the lay group; for professional standards and procedures, upon the professional groups; for mutual consultation on all matters of joint interest, upon both groups."

Senator MURRAY. That concludes the witnesses. One of the witnesses that was to be here this morning was Mr. Joseph A. Clorety, Jr., vice chairman of the American Veterans Committee. He was not able to be here, so I will have incorporated in the record the statement which he intended to present this morning.

(The statement referred to is as follows:)

STATEMENT OF JOSEPH A. CLORETY, JR., VICE CHAIRMAN OF THE AMERICAN VETERANS COMMITTEE (AVC)

Mr. Chairman and members of the subcommittee: The American Veterans Committee appreciates this opportunity to appear before the subcommittee to state its views on the subject of medical care for the American people. As citizens and as veterans, we believe that a broad, complete health insurance program should be adopted. We have studied three of the bills now before the subcommittee: those introduced by Senators Thomas, Taft, and Hill. Of these we prefer the Thomas bill (S. 1679) and, with your permission, I should like to tell you why.

All of us—and this includes us as Democrats and Republicans, the American Medical Association and the men who pay the medical bills—agree that something must be done to improve the Nation's health. We agree that far too few people can afford adequate medical care for illness and that even fewer can afford to pay for the prevention of illness. We agree that the situation is bad, but we disagree considerably about what should be done.

To achieve our objective of a strong, healthy Nation, we must provide many things. Of course, we must make it possible for people to see doctors when they are sick. But we must do more. We must assist schools so that they may turn out qualified medical personnel in larger number, we must aid research programs for the detection and cure of disease, we must build more hospitals, and we must provide wider distribution of medical personnel. It seems to us that the Thomas bill makes the longest stride toward our objective.

The first part of our objective is to make it possible for people to see doctors when they are sick. I am sure that it has been pointed out to this subcommittee many times that the very rich and the very poor have access to proper medical attention. However, 80 percent of the families in this country would be in a jam if suddenly hit by a serious operation or extensive medical expenses. They postpone visits to the doctor because they cannot afford to discover that they are ill.

I would like to point out the difference in coverage by these bills. The Thomas bill would cover most of the people of this country. On the other hand, the Hill and Taft bills limit their benefits to those who can prove that they are unable to pay the costs. In such cases, regardless of the intent, this aid would be stigmatized as "charity." As long as this stigma remains, most people would prefer to postpone needed medical attention—perhaps until it is too late. Not only because of the indignity, but also because of the danger, the American Veterans Committee feels that Americans should not be required to prove their inability to pay medical costs. The Thomas bill provides medical care without such restrictions.

Further, we must provide professional health workers in increasing numbers. This means not only doctors, but dentists, nurses and others skilled in the fields of health. Undoubtedly, the shortage of doctors has been emphasized before this subcommittee. However, the need for dentists, sanitary engineers, nurses, and laboratory technicians is less dramatic but also important.

A comparison of the bills points out differences in this respect: The Thomas bill provides a wide program to make up these deficiencies. On the other hand, the Taft bill would limit aid to medical schools and in the meantime set about to determine what shortages exist. The Hill bill makes no provision at all for increasing the number of people trained in the medical sciences. The Thomas bill, however, provides a comprehensive program of assistance to schools of medicine, dentistry, nursing, public health, and sanitary engineering, with provisions for the construction of new schools and the expansion of existing training facilities. Such a positive program seems to us to be highly desirable.

The last of the steps which AVC feels must be taken to achieve our objective is a provision for wider distribution of medical personnel. The present concentration of doctors in urban areas has undoubtedly been brought out many times. The simultaneous shortage in rural areas has also been discussed, and yet it is becoming more severe. The need for a better balance of medical services requires action.

Here again a comparison of the three bills is interesting. The Thomas bill outlines positive action to be taken. The Taft bill requires that the State "provide inducements to physicians and dentists to practice in areas which, without such inducements, would be unable to attract needed physicians or dentists." The Hill bill requires generally that States "provide for a survey of areas in the State which are unable to attract practicing physicians, and recommend methods for encouraging physicians to practice medicine in such needy areas." The Thomas bill, however, sets forth specific steps to be taken and grants, loans, and guaranties are provided for medical services to people in rural and other shortage areas. This clearly defined course is, in our opinion, necessary.

To summarize AVC's feelings about the three bills: The Taft bill makes certain provisions to extend and make more available good health facilities. It provides, for example, for health examinations of school children; it would extend the Hospital Survey and Construction Act; it would assist the States in establishing local public health units. We do not feel that it goes far enough.

This bill extends the availability of medical care to those who are willing to prove their inability to pay the costs themselves. This provision places the stigma of charity on such aid. Even if the bill were to provide enough money to cover the costs of aid to everyone who would actually need it, and we don't think it would, most independent, middle-income Americans would go without needed care before asking such aid.

The Hill bill attempts to improve medical facilities by aid to voluntary prepayment plans. However, it would not make those who cannot afford the premium payments members of such plans. Dr. Paul R. Hawley has testified before this subcommittee that this bill merely provides the mechanism for medical care of the indigent. Such voluntary plans would be paid on the basis of the service they provided to the indigent. It would not, therefore, be health insurance or prepaid medicine for those who could not afford the premiums. This service, too, has the stigma of "charity."

Also, there are many areas where there are no such voluntary plans. We wonder what services will be given to residents of these areas. The bill provides for an appropriation "sufficient to carry out the purposes of the act." We wonder what estimates have been made. The bill states that its purpose is to "make a high quality of hospital and medical care available to all persons in each State." We see nothing further in the bill that would assure quality care.

Furthermore, this bill makes little attempt to expand and improve the general health facilities available to the Nation. While we approve of voluntary health insurance plans, we don't feel that their present expansion holds the answer to the country's health problems.

The Thomas bill, on the other hand, offers a comprehensive program for health insurance, while retaining for recipients of such care their freedom and dignity. It is not socialized medicine—we do not advocate that. It provides free choice to patients and doctors and it offers incentives for providing service in areas where it is most needed.

As veterans, we are entitled to care at veterans' hospitals and clinics for service-connected illnesses, and those of us who are indigent have full coverage. We feel that this bill provides for even better care, and certainly more freedom. We would like to see the assurance of good medical care extended to the whole Nation.

The bills which I have been discussing are all aimed at making this a healthier nation. However, they differ markedly in their scope, method of approach, and degree to which they cover the American family. Of the three we consider that the Thomas bill offers the best approach to a broad and complete health insurance program. The Thomas bill permits us to pool our health efforts as we do our social security. Our objective requires the participation of the whole Nation.

Senator MURRAY. That concludes the hearing by this subcommittee, and we now adjourn.

(Whereupon, at 3:40 p. m., the subcommittee adjourned.)

APPENDIX

(Senator Donnell submitted the following materials for inclusion in the record:)

[From the Washington Evening Star, January 20, 1949]

On the Record—Public Medicine Proposal Seen as Way to Wreck Public's Health and Purse

(By Dorothy Thompson)

Public medicine—"free" medical care supported by a tax on pay rolls—has been demanded by President Truman, appears in the proposed new budget, and is supported by humanitarians who recognize that many people who need medical care are unable to get it at a price they can afford. This column does not deny this, and later will propose some ameliorations.

But what must be emphasized is that the statement of a need never implies the remedy. The advocates of public medicine have failed to describe the problem and have rushed to that universal panacea for everything, "Let the Government do it," drawing entirely false analogies between the Government's capacity for success in one field and another.

It is argued: "We have free public education; why not free medicine?"

PROBLEMS DIFFER RADICALLY

But the problems are radically different. The school question can be collectively solved, while medical care, if not to be worthless, is a strictly individual problem, as diverse as there are human personalities.

In education, the State undertakes to give instruction to persons between certain ages, under a fixed curriculum of subjects, and according to agreed-on standards. The number to be taught is statistically computable; the amount and duration of the effort are defined, and the cost, therefore, can be budgeted. Education is administered in classes and, according to the standards adopted, the number of teachers necessary also is statistically ascertainable. Nor are the students educated according to subjective standards of what each thinks.

None of these standards or computable needs is present in public medicine. It undertakes to furnish service to every citizen of any age who is sick, or who thinks he is sick. Possible diseases or phases of them are almost limitless and range from hypochondria through thousands of organic disturbances to psychoneurosis.

In each person several afflictions may be combined and each symptom may arise from a score or more of causes. Almost no human being, over a certain age, is perfectly well. As a result of these facts, the experience of public medicine, in every single country where it has been adopted, is that doctors' offices and clinics are thronged with persons who are as well as their years justify, but whose demands can wreck the treasury.

No system of socialized medicine ever has been able to devise a budget. If Congress expects to cover costs by the proposed pay-roll tax, let this columnist predict that the costs will not be so covered.

The British system exhausted its annual funds within 3 months. None ever has been supported from earmarked funds. This, too, must occur from the nature of the situation.

COLLECTIVE PRESCRIPTIONS

Proper diagnosis is impossible. In England doctors ask, "How many persons here have headaches?"—and write a common prescription. But a headache may arise from a hang-over, eyestrain, sinus trouble, psychic disturbances, brain tumor or a myriad other causes. In collective medicine, headache patients all get barbiturates.

Public medicing is a bonanza for drug companies, optical firms, etc., for it always turns into medicine by prescription—collective prescription.

Public medicine runs into infinity. It is as impossible to compute the necessary number of doctors as of patients, and constantly mounting demands force a break-down of medical standards, beginning with training.

Every good physician must undergo individual training. He cannot learn to tell one sort of heart tremor from another by listening to a classroom lecture. He must take a stethoscope in his own hands, listen himself, learn under individual guidance. There is no way of vastly increasing the number of competent doctors except by turning the present ones to teaching—doing, meanwhile, without medical service.

A famous New Zealand physician, recently in Canada, stated in a public interview: "Public medicine in New Zealand is a disaster. It is turning our people into a race of hypochondriacs."

It also is breaking the public bank.

The American Congress has not even begun to think what public medicine will do to the public purse and public health. When and if it does, it will find another way to meet real needs.

[Extracts from the Economist, December 25, 1949, London, England]

Paying for Sickness

Rumors have been rife about the cost of the national health service almost from the day it was introduced, but very little hard information has been available on the extent to which the estimates were being exceeded—that they were being exceeded was accepted as a matter of course. Last week, however, in a parliamentary answer, the Minister of Health gave the actual amounts that had been spent from public funds, excluding the amount spent by local health authorities on their services, on the five main branches of the health service in its first 5 months, and the figures are reproduced below, together with the original estimates for the 9 months, July 5, 1948, to March 31, 1949.

[Thousands of pounds]

	Estimate, 1948–49 [1]	Spent July 5 to Nov. 30 [1]
Hospitals	107,196	58,000
General medical services	27,500	7,983
Pharmaceutical services	11,450	5,439
Dental services	7,150	5,542
Ophthalmic services	2,080	4,048

[1] England and Wales only.

It should be pointed out that the amounts actually spent do not represent the total liabilities incurred in this period. Even so, the figures bear out the general impression of the working of the health service: that the general practitioners have some cause for their complaints that they are underpaid; that the cost of prescribing accords roughly with the estimate; and that the dentists and opticians are doing extremely well.

General practioners are paid a capitation fee for each patient on their list and a mileage payment for visiting; there is also a special inducement fund for doctors in under-doctored or sparsely populated areas, and a basic salary of £300 a year, for which any practitioner can apply, in the first instance to the local executive council and, if rejected, on appeal to the Minister. This basic salary has to be paid out of the pool allotted to each excessive council for payment of the capitation fees to the doctors in their area. Doctors who receive it are given a capitation fee one-seventh less than the normal rate. Nevertheless, its effect is to subsidise the less-successful doctors at the expense of their colleagues. This charge on the pool, together with the fact that the first instalment of the sum allocated to the executive councils was less than it should have been, the Minister preferring to settle up any deficiency at the end of the year rather than to overpay to begin with, has been the cause of much discontent. The £8,000,000 shows as spent in the first 5 months really represents the payment of the first 3 months, as general practitioners are paid quarterly. In the 9 months to March 31, 1949, on the same basis, doctors would be paid £24,000,000,

£30,500,000 less than the estimate, which was calculated on the assumption that fewer doctors would join the service than has in fact been the case. There does, therefore, seem to be some substance for the doctors' complaints—at present being investigated by a sample survey of their earnings—although it has repeatedly been said that underpayments will be made up in the final settlement.

The amount spent on the pharmaceutical service should not be regarded too favourably. If the same rate were maintained throughout the 9 months, the total would be £9,790,000 compared with an estimate of £11,450,000. But dispensing is largely a seasonal occupation, and the peak period has still to come.

The actual liability for the dental and supplementary ophthalmic services is likely to be much bigger than the amount spent in the first 5 months indicates, for the rate has increased from month to month. Indeed, it was estimated in the British Dental Journal of November 19 that the cost of the dental service was then running at the rate of £28,000,000 in a full year, which would be a rate of £21,000,000 for 9 months. Mr. Bevan's decision to cut out the top off dentists' earnings should reduce the cost to a certain extent, but it is difficult to see how payments that are based on items of treatment performed can be anything but heavy. One need not suggest cynically that digging holes and filling them up again is the classic method of making employment. The fact is that there is a heavy, unsatisfied demand for treatment, which dentists are naturally trying to meet. If the fees for each item of treatment are greatly reduced, it will only lead to the danger that dentists will work excessively long hours to earn more money.

The truth is that the ideal method of paying the practitioners in a free health service has yet to be found. Payment by salary is hard on the patient, for it denies him free choice of doctor or dentist—doctors paid the same amount will tend to do the same amount of work; the lack of incentive in a salaried service also discourages the best people from entering it. Payment by items of service is hard on the taxpayer. Payment by capitation fee is hard on the practitioner; it means that, no matter how great the demand for his services from his patients, he gets no additional award. Nevertheless, it does seem the best of the three methods. It enables the cost of the service to be estimated fairly closely; it ensures free choice for the patient; and it provides some incentive for the practitioner. Is there any reason why it should not be tried out in the dental service?

There remains the hospital service, which accounts for well over half the total cost of the health service. The figure given by Mr. Bevan for the cost of the hospitals in the first 5 months does not seem unduly high. It would give a total of £104,400,000 in the 9 months, which is actually just below the estimate. But the budgets of the regional hospital boards for the year 1949–50 give a less favourable picture. They estimate a total gross expenditure, including capital expenditure, of £157,680,000. This compares with the Ministry of Health's estimate for the regional boards' expenditure only—that is, excluding the teaching hospitals' expenditure—in the present year of £129,414,000 when calculated on an annual basis.

In fact, it is not so much the cost of the hospital service at present that causes anxiety as the mounting cost from year to year as plans for expansion are framed and put into operation. At the moment, the maintenance cost of a hospital bed shows big variations from hospital to hospital, both in London and in the country as a whole. All, however, have this in common—the cost is increasing from year to year. In London, the average cost of a bed in the former voluntary general hospitals was £11 7s. 6d. a week in 1947. In the whole of England and Wales, 388,000 hospital beds were taken over on July 5. If the eventual cost of each is put at £10 a week, it gives an expenditure of £194,000,000 a year on in-patient treatment alone, let alone out-patient treatment, the cost of other services and the cost of teaching and research. Even if, by the economies of large-scale management, it is possible to maintain a hospital bed efficiently at a cost of, say, £7 a week, the total cost is still likely to rise because of the planned increase in the number of beds.

It is true that Mr. Bevan has not yet approved the regional boards' budgets. He may decide that they will have to be cut, and so may any future Minister of Health in subsequent years. But it would be difficult for him to square a drastic cut with the duty imposed on him by the first clause of the National Health Service Act:

"to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales, and the prevention, diagnosis, and treatment of illness * * *."

As the secretary of a regional board points out in a letter on page 1061 this week, no one in close touch with the hospital service and aware of the great needs to be met can be expected to impose a check. Only the Minister can place a limit on the hospitals' expenditure, and there will be constant presure on him to raise it.

Of all the costly social services of the modern state, a health service is likely to prove the costliest. Far more than education, more even than old-age pensions, the treatment of sickness has a popular appeal that is very difficult to resist. It is certainly arguable that fewer man-hours are lost to industry by sickness treated than by sickness untreated, and that a nation made healthier through the resources of a health service will have a greater productive capacity. But this has yet to be proved. All the evidence seems to show that, in spite of the great advances in medicine, the burden of treating sickness increases from year to year. When one illness disappears, there is always another to take its place—science is overcoming many diseases, but it has yet to conquer disease. Until it has done so, the nation will have to face, so long as the principle of a free health service is maintained, a mounting bill for its maintenance.

[From the Washington Evening Star, May 26, 1949]

Move to Cut Dental Fee for British Free Care Arouses Profession

(By William McGaffin, foreign correspondent of the Star and the Chicago Daily News)

London, May 26.—Britain's system of socialized medicine continues in the throes of its growing pains.

Health Minister Aneurin Bevan has taken some drastic swipes at the mounting costs of the health service—now running at an estimated $1,200,000,000 yearly—much more than originally planned.

Singled out for the economy ax were hospitals and dentists, and the defenders arose to protest about both.

DENTISTS DEFENDED

Dentists often have been criticized for abusing the new system and using it to get rich quick. But the London Sunday Observer took a stand against the 25-percent cut in their fees with this observation:

"Bevan, in his anxiety to reduce the alarming costs of national dentistry, is giving an inaccurate impression of dentists' earnings. The figures show that some two-thirds of the profession are not earning more than the £4,000 ($16,000) a year gross, which has to cover high overhead expenses, recommended by the Spens Committee. Bevan's new 25-percent cut will fall unfairly on the conscientious craftsman who often gives more time to a particular job than the scale allows, while the dentist who hurries and scrimps on his work will still do very well.

"Meanwhile, in many areas the valuable school dental service is near collapse. Dental officers, paid much less than they could now earn in practice, are resigning and local authorities are refusing to negotiate new scales."

DENTISTS FURIOUS

The dentists themselves are furious about the cut which takes effect June 1 and some are threatening to leave the national health service and return to private practice.

If this happens it will mean even longer waits for a public that gets its dentistry done on the state. There already is a serious shortage of dentists.

Even greater concern, however, has been aroused by Mr. Bevan's slashing of $38,000,000 from the hospital budget. There already is grave shortage of hospital beds and, according to the estimate of the London Daily Telegraph, this cut may mean the further reduction of 30,000 beds.

The London Sunday Express, in an editorial analysis of what's wrong with the health service, blames "administrative extravagance" and "undue demands made by the citizens" for much of the unexpectedly high cost.

To help remedy this situation the paper would reduce administrative expenses and at the same time have the public pay a small fee for its "free" medicine in addition to the weekly contribution taken out of the pay envelope.

[Extracted from American Economic Security, vol. VI, March 1949, Chamber of Commerce of the United States]

"DISINCENTIVES" IN BRITISH SOCIAL SECURITY

(By Elizabeth W. Wilson, Ph. D)

The cost of a social-security system cannot be measured just by dollars and cents paid to the aged, the sick, and the unemployed. One must also take account of the potential national product never produced because of decreased incentives for production.

This past summer, Britain inaugurated an all-inclusive social security system, a sort of cotton batting to soften the economic bumps from all the misfortunes to which man is heir. No longer does the average Englishman have to work to save for his old age, his children's education, possible sickness, or other economic disasters. As a consequence, many a British businessman now complains that the workers do not care whether they keep their jobs or not. The system itself has removed the incentive of fear from the productive economy.

The other usual incentive to work is the desire to get things—nice things—for one's family and one's self. The new British social-insurance law has had an indirect effect on this. The system is to be financed, at least in part, by a flat weekly tax of about $1 for an adult male employee and 80 cents for female, with slightly lesser amount from the employers. Many of the younger employees object: Old age seems far away to them; unemployment is not an immediate danger; they are rarely ill. Indeed, student nurses threatened to stop nursing—although there is a great shortage of nurses in England—unless their pay was raised to more than cover the new tax. The crux of their objection was that, because of the new tax, they had little cash to spend.

FURTHER LOSS OF INCENTIVES

The employers' tax must inevitably increase the dissatisfaction, for much of it has to be passed on to workers, as consumers, in the form of higher prices. Thus, because of the social security taxes, British workers are finding the satisfaction of present desires less easy.

Some say the effect should be to spur on production. Perhaps it would, if the worker did not know that by working hard he will soon reach a wage class where 45 percent of his income will be taken in income tax, and that at just a little higher level, surtaxes begin. Recent word from England is that certain dentists are taking 2 days a week off to avoid these surtaxes. Yet, at best, there are only one-seventh the number of British dentists that would be necessary to give the people of England adequate dental care. The English need every dentist on a full-time schedule.

But the whole scheme is not to be paid for by the employer and employee taxes. In fact, about 75 percent of the cost of socialized medicine will have to be paid out of the general exchequer—more than a billion dollars. To raise this amount from income taxes, the standard rate would have to be increased to 55 percent. Would such a raise be a help toward more production? Even Sir Stafford Cripps admits that it would be a "disincentive."

What about a sales tax? Already the price of many articles is increased from one-third up to the full value by what the British call a purchase tax. Any further increase would put more and more things out of reach of the workers, thus serving as a further "disincentive."

What of excise taxes? Even now, the levy on tobacco is so high that a pack of cigarettes costs 70 cents. There is a 15-cent tax on a pint of beer. Even simple pleasures are out of reach for many British people. In such circumstances, how could the imposition of more taxes to pay the social security bill create a desire to produce more?

But Lord Beveridge says, "Only slaves need an incentive to produce." One might question whether slaves were not the very ones who need no incentives. If the father of British social security is right, there are many slaves, at least in America.

IMPLICATIONS FOR AMERICA

If we get an all-inclusive social security system here, much the same analysis will apply to us as applies to Britain. There will be taxes and more taxes—taxes that will deprive people of spending money and taxes that will push prices higher, so high that they may render unobtainable many things American workers now have.

The benefits will, of course, remove the incentive of fear as to various economic consequences. In itself this is good, provided that present fears are not replaced—as they have been in England—by an ill-defined but very real fear of what is to come, based largely on the dread of regimentation by a huge, unproductive bureaucracy, the inevitable adjunct of a planned economy.

[From the Leicester Mercury, December 28, 1948]

COUNTRY DOCTORS "BADLY HIT" BY HEALTH SERVICE

The whole question of doctors' capitation fees under the National Health Service, and particularly the situation in regard to country doctors, is under review by the British Medical Association.

They are making a survey of the position of their members in the light of experience since the act became operative, and expect to place their case before the Minister of Health (Mr. Aneurin Bevan) early in the new year, an official of the association stated today.

An inquiry is being made in a rural district, a rural county and two towns, one mainly manufacturing and the other residential, to get a representative view.

"But we are pressing now for an immediate reconsideration of the position of country doctors, apart from the general question of capitation fees," he explained.

"We have ample evidence that scores of doctors in the rural areas are so badly hit that they find it difficult to make a living.

"Their private practices have gone and the districts are so scattered that it is impossible to find sufficient patients to ensure an adequate income."

[From the Daily Telegraph, April 1, 1949]

KEEPING WELL A "DUTY"—WHAT BUREAUCRACY WANTS TO KNOW

(From Sir Ernest Graham-Little, M. D., M. P.)

To the EDITOR OF THE DAILY TELEGRAPH.

SIR: Neither the public nor the medical profession realises the radical difference which a totalitarian conception of health services has already caused, as regards both patients and doctors.

The Beveridge Report conveyed this new conception with commendable frankness. It insisted that, with the lavish scale of benefits proposed, it was imperative that "the state should make determined efforts to reduce the number of cases for which benefit is needed."

It was further insisted that the individual patient should realise that it was his "duty (to the state) to be well." The state, therefore, must be able to control the issue of medical certificates, and to check the measure in which medical practitioners and patients co-operate in that duty. The state must also be able to withhold benefits from patients who fail in that duty.

Early in the negotiations between the Minister of Health and the Medical Negotiating Committee, in 1944, the Minister made it clear that "control of the profession was desired in order that the State might have a firm hand over the issue of certificates." Access to, and ultimate possession of, medical records of state patients became a primary objective of the ministerial departments concerned.

In pursuance of this objective, a series of regulations was imposed by the Minister in the Statutory Instruments 506 and 507, of March, 1948. These oblige the doctor "to keep records of the illnesses of his patients and of his treatment of them in such form as the Minister may from time to time determine."

The profession's objection is not to the compilation of this information, but to its disclosure, for these intimate records are to be accessible at any time for inspection, and even for custody, by several local committees, consisting largely of lay persons.

Such requirements obviously break the Minister's promise to the public, in an official leaflet, that "your dealings with your doctor will remain, as they are now, *personal and confidential*" [the italics are the Minister's].

The regulations have a further equally serious result. They compel the state doctor to break the Hippocratic Oath, which in all civilised countries has guided the professional from time immemorial. The original oath runs:

"Whatsoever in the course of practice I see or hear (or outside my practice in social intercourse) that ought not to be published abroad, I will not divulge, but consider such things to be holy secrets."

It is of particular significance that the new Fellowship for Freedom in Medicine has protested against these requirements and called for their withdrawal in the new amending bill now under consideration.

Yours faithfully,

E. Graham-Little, *House of Commons.*

[From the Daily Telegraph, January 8, 1949]

Doctors in the New Era—Their Illusory "Freedoms"

To the Editor of the Daily Telegraph:

Sir: The grim account of the new Health Service by Dr. Guy Dain, chairman of the Council of the British Medical Association, does not overstate the serious defects of the system, which, it must be remembered, has not yet been very severely tested.

That the average urban practitioner is heavily overworked and the average rural practitioner seriously underpaid cannot be denied. These facts in themselves constitute a grave threat to the freedom of doctors to carry on their work in accordance with the high standards to which medicine has attained in this country.

It is all very well for Dr. Dain to claim that the state service has established certain freedoms, but the freedoms that he cites are rendered largely illusory by the provisions of the act, as indeed emerges from his own recital of the facts.

What sort of freedom is it which allows a doctor "to take private or state patients as he wishes" when there are no private patients for him to take? Nor is it much use for a patient to be free to remain outside the scheme if he cannot afford to do so.

The Minister of Health is trying to kill private practice, or at least to reduce it to an absolute minimum by making it available only to the financially privileged few. So he refuses private patients their drugs at state expense and puts up the price of private accommodation in hospitals far above the actual cost.

Even more important is the question of clinical freedom. To give his patients of his best a doctor's mind must be reasonably free from personal anxiety and he must have time to exercise his skill. If, as Dr. Dain admits, many doctors now have serious financial worries and are grossly overworked, how can he maintain that "the doctor is free from interference with his clinical judgment?"

As vice chairman of the Fellowship for Freedom in Medicine, I see a great number of letters from doctors all over the country. The rushed and worried lives that many of them are now leading appalls me because of the lowered standards of work which must inevitably follow.

The galling thing is that it is those doctors with the highest ideals of service to their patients who are most affected.

Yours faithfully,

R. Hale-White.

[From Money-Matters—A Bulletin of Economic Interpretation, May 1949]

New Zealand Figures Give Picture of Cost of a Welfare State to Public and Economy

What is the cost of a welfare state, to the public and to the economy at large? New Zealand provides an illuminating answer. Social experimentation and increasing Government paternalism have been characteristic of New Zealand for more than a generation. A decade ago, coverage and benefits under social-security legislation were expanded so greatly that New Zealand would appear to have reached the ultimate in government assumption of responsibility for the individual and his welfare.

The definition of social security in New Zealand goes far beyond that prevailing in the United States and includes governmentally provided services and benefits, like medical care, that in this country have been traditionally regarded as an area of individual responsibility.

Official figures show that social services dominate the cost of government in New Zealand, and have for years. Here is an official view of New Zealand budget, prewar and postwar, as presented to the General Assembly recently by Minister of Finance Walter Nash (in millions of New Zealand pounds):

Expenditure	1938–39 fiscal year	Percent of private income	1947–48 fiscal year	Percent of private income
Social services	£20.0	10.0	£60.0	13.2
Interest on public debt	7.6	3.8	18.0	4.0
General government	6.1	3.0	11.6	2.5
Maintenance of works and services (net)	3.8	1.9	5.7	1.3
War and defense	2.2	1.1	11.4	2.5
Stabilization (subsidies)			11.0	2.4
Development of industry	2.5	1.2	5.6	1.2
Total taxation	37.8	18.8	122.3	26.9
Total private income	200.7		[1] 455.0	

[1] Estimated.

The classification of "social services" includes education, but its major element of cost is the social-security program. Social-security expenditures in the 1947–48 fiscal year, for example, came to over 40,000,000 pounds, or two-thirds of the total outlays for social services. Thus the New Zealand social-security program took virtually a third of every penny of taxation collected by the Government in the 1947–48 fiscal year.

The cost of the New Zealand social-security program has been rising steadily, and has more than doubled in the last 5 years alone. Old-age pensions and family benefits are the biggest single items of cost. Next come medical benefits, which are provided for the entire population under a compulsory Government insurance plan.

COST OF HEALTH PLAN

Compulsory health insurance has been in effect in New Zealand for a decade, and its cost has jumped every year. In the 1948–49 fiscal year, outlays for the medical plan are officially estimated at a new high of over 7½ million pounds, an increase of close to 50 percent in the last 5 years and equivalent to more than a third of the cost of all social services before the war.

Payments to doctors and drugs are the two big factors in the rising cost of New Zealand's compulsory health insurance. The former has increased from about 1.3 million pounds in the 1944–45 fiscal year to approximately 2.3 million pounds in the fiscal year ended last March 31. The cost of providing "free" drugs has gone up from less than a million pounds to nearly 1.7 million pounds in the same period. These two benefits together added up to nearly 4,000,000 pounds in the 1948–49 fiscal year, or over half the entire cost of the compulsory health insurance plan.

Proportionately, social security costs in New Zealand are even higher than in Great Britain where comparable outlays in the budget recently presented to Parliament represent about 22 percent of all British Government expenditures for the current year as against one-third for New Zealand. However, expansion of social security in Great Britain is more recent and its compulsory health insurance plan has been in effect for less than a year.

New Zealand has a special social-security tax of 7½ percent on all income, business as well as individual, and this is levied on top of all other taxes including income taxes. However, the receipts from this tax, though very large, have regularly fallen far short of meeting the costs of the social-security program. As a result, the Government has had to make up the difference out of general revenues, and these Government contributions in the last 3 years have ranged from a third to a half of the costs of the program.

CONTRAST WITH UNITED STATES BUDGET

An interesting contrast is provided in a study of the American Government budget as against that of New Zealand. In this country the recent war and the current "cold" war are the dominant cost factors, and are certain to be for years to come. Proposed expenditures for defense, interest on the public debt, and foreign aid alone add up to over 63 cents of every dollar of the estimated cost of our Federal Government in the coming year. This reflects the extent to which the

American people are meeting the responsibilities of foreign rehabilitation and the defense of western civilization. Such expenditures are relatively minor in the New Zealand budget.

Thus, with conditions as they are, any major expansion of the American social-security program beyond prudent levels seems certain to have significant individual and economic repercussions, by adding greatly to the load which has already made the individual tax burden in this Nation the highest in the world. This burden was about $325 per capita in 1946, and has increased substantially since. The American figure is in the neighborhood of $100 per capita higher than the individual tax burden in New Zealand.

THE NEW ZEALAND FUND

The following table gives the high lights of the operations of the New Zealand social-security fund in the last five fiscal years (in millions of New Zealand pounds):

Income

Fiscal year	From social-security tax	From general revenue	Expenditures
1944–45	£13.7	£4.5	£19.3
1945–46	14.6	7.0	23.0
1946–47	22.4	18.0	36.8
1947–48	26.2	16.0	40.4
1948–49 [1]	30.0	15.0	42.7

[1] Estimated.

Source: Official New Zealand reports.

[From the Washington Post, January 2, 1949]

CANADA IS AHEAD IN HEALTH PLANNING

(By Graham L. Davis, Director, Division of Hospitals, W. K. Kellogg Foundation, Battle Creek, Mich.)

Deficiencies in the health services of Canada are practically the same as in the United States. Economic and social conditions are similar, except that the population is more homogeneous in Canada and the variation between the Provinces in per capita income is not as great as between New York and Mississippi. Canada's smaller population also reduces the size of its problem.

After years of discussion and planning Canada decided in 1945 that a national health insuranc program should be introduced. But when it came to working out the actual details, obstacles were evident that in some instances appeared almost insurmountable. Not the least of these was the shortage of physicians, dentists, nurses, technicians, dietitians, and other health workers and of hospital beds, caused by depression, war, and increased public demand for service.

There is not much point in stimulating further demand with compulsory health insurance when existing demands cannot be met. Taxing the people for something that cannot be delivered does not make sense. Compulsory hospital insurance in Saskatchewan, with practically unlimited service benefits, doubled the demand for service in a year. How much of this increase is abuse or unnecessary and how much represents actual need is a debatable question.

My impression, gained from conversations with Paul Martin, Minister of National Health and Welfare, and Dr. G. D. W. Cameron, Deputy Minister of National Health, and from participation in a recent 3-day conference at Ottawa, is that Canada is not nearly as certain now as it was in 1945 that the compulsory health insurance proposals were the best answer to the problem of financial medical care. For this and other reasons, Canada in 1948 adopted a different approach.

AN ENABLING GRANT

The proposed grants in 1945 for health planning and organization were conditioned upon the Provinces agreeing to adopt compulsory health insurance. Prime Minister Mackenzie King, in his statement to the House of Commons last May 14, said the 1948 health survey grants "were not to be conditional upon the Provinces undertaking to enter a health insurance plan."

The Prime Minister went on to say: "The purpose * * * is to assist the Provinces in setting up the machinery which will be necessary to insure the most effective use of the other health grants now being proposed, and in planning the extension of hospital accommodation, and the proper organization of hospital and medical care insurance."

The $625,000 grant for surveys apportioned to the nine Provinces on the basis of population, is intended to pay the full cost of a complete inventory of all health facilities and services—hospitals, medical care, and public health. With all the facts before it, each Province will be in a position to determine its health needs and develop an intelligent plan to meet those needs.

The Provinces undoubtedly will decide that the principle of contributory health insurance is the basic method that should be employed to finance medical care, including hospital service. Therefore the Ministry of National Health and Welfare has secured the services of Dr. Fred Jackson, Deputy Minister of Health of Manitoba, on a leave of absence for 2 years, to direct its health-insurance studies.

Dr. Jackson invited me to participate in the first conference of provincial health survey directors at Ottawa.

ABLE LEADERSHIP

The first day of the conference was devoted largely to exchange of experiences in the organization of provincial surveys and to discussion of the best methods of recuring uniformity in the collection of the necessary data as to hospitals and the number and distribution of physicians, dentists, nurses, technicians, and other types of workers in the health field.

Canada does not have a law, such as Public Law 725, the Hospital Survey and Construction Act in the United States, that prescribes certain uniform methods that must be followed by each State in surveying its hospital resources and needs and producing an intelligent plan to meet those needs. Canada does, however, have a Ministry of National Health and Welfare fully as capable as the United States Public Health Service to take the lead in organizing such cooperative effort. In the Dominion Bureau of Statistics, a large volume of valuable data on health facilities and services is available.

The second day, advisory committees for medicine, nursing, public health, and hospitals attended the conference. Representatives of the Canadian Medical Association, Canadian Nurses Association, and Canadian Hospital Council indicated a feeling that the provincial health departments were not seeking their advice and assistance at the policy-making level in organizing the surveys.

This apparent ignoring of the voluntary agencies was not intentional at all. So little time had elapsed since announcement of the grant that the provincial departments had done well just to get survey staffs together. The discussions cleared the atomosphere.

The shortage of trained personnel of all kinds came in for lengthy discussion. The shortage of nurses appears to be as great or greater in Canada and for much the same reasons as in the United States. There is one important difference: the Canadian schools of nursing have more good applicants than they can admit. One reason is that Canada's hospitals are smaller in the Prairie Provinces.

One suggested solution is for the Provincial universities to assume responsibility for the basic science training and assign the students to the smaller hospitals for clinical experience. Resistance to the practical nurse on the part of the registered nurse appears strong in the eastern Provinces, but out west practical-nurse-training programs are being expanded.

NURSES OBJECT

On the third day the survey directors and advisory committees met separately. It soon developed both groups were greatly concerned about the same thing, a proposed national study of nursing education and nursing service by an independent commission composed of representatives of the health professions, the consuming public, agriculture, labor, industry, and education. It was tentatively decided that a 2-year study should be made, to cost about $25,000 a year and to be financed from the public health research grant.

The nurses were not very happy about it, because they insisted that nursing education was their responsibility and for that reason the majority of the commission should be nurses.

It was decided that the survey directors would inventory nursing resources in each Province, attempt to determine needs and make tentative recommendations as to how these needs should be met, but that the independent national commission would attempt to develop over-all policy.

Grants to the Provinces the first year amount to $30,125,000 (including the $625,000 for health surveys), or about $2.50 per capita. On a comparable per capita basis in the United States, the figure would be $370,000,000.

These are the other health grants in the order presented by the Prime Minister:

General public health	$4,400,000
Tuberculosis control	3,000,000
Mental health care	4,000,000
Venereal disease control	500,000
Crippled children	500,000
Professional training	500,000
Public health research	100,000
Control of cancer	3,500,000
Hospital construction	13,000,000

The general public health grant is on the basis of 35 cents per capita and will increase 5 cents per capita each year until it reaches 50 cents, or $6,000,000. The Provinces must agree to use it to expand existing services, which will be difficult with the present shortage of personnel.

The tuberculosis and venereal disease control grants are distributed one-half on the basis of population and the other half on the basis of the tuberculosis death rate and the number of new venereal disease cases reported. After 2 years the tuberculosis grant will increase to $4,000,000.

PROVINCES CONTRIBUTE

The grants for the prevention and treatment of crippling conditions in children, for mental health and for cancer control are distributed on a population basis but the Provinces must match the money for cancer diagnostic and treatment centers. The mental health grant will increase progressively to $7,000,000 annually. On the same per capita basis in the United States, this would mean $85,000,000.

The professional training and public health research grants are allocated on the basis of acceptable projects submitted. Canada has recently established a National Institute of Health and it has a National Research Council.

Of the hospital construcion grant, the Prime Minister said: "If, as the first stage in health insurance, hospital insurance were now to be introduced on a contributory basis, the demand that would arise for hospital accommodation simply could not be met."

The $13,000,000 a year for hospital construction during the next 5 years will be allocated on a population basis. On a per capita basis, it is about twice the $75,000,000 provided annually in the United States. Another difference is that the grant in Canada is available to hospitals everywhere, while in the United States a system of priorities channels the money to hospital construction where the need is greatest. Canada may establish prioriies based on need if it appears advisable, however.

The grant is $1,000 per bed for short-stay general hospital beds and $1500 for long-stay patients such as mental diseases and tuberculosis. The Provinces must match these grants.

The larger grant for long-stay patients is intended to stimulate construction where the need is greatest. Canada thinks it is neglecting its mentally and chronically ill more than the acutely ill and injured. The same can be said for this Nation.

The $2,000 per bed available from the Dominion and Provincial Governments for general hospital beds is about 20 percent of the cost, compared with one-third of the cost from the Federal Government in the United States.

AHEAD IN PLANNING

This Nation is about 2 years ahead of Canada in its national hosiptal construction program, except that Canada has always coordinated the construction of hospitals for veterans with the construction of hospials for everybody, and this Nation has not. But Canada is outstripping the United States in its planning for an over-all national health program.

What Canada is doing is essentially what the National Health Assembly last May recommended should be done in the United States and what Oscar R.

Ewing, Federal Security Administrator, recommends in his report to President Truman on national health goals for the next 10 years, with one important exception. Ewing recommends national compulsory health insurance now; the National Health Assembly does not.

[From the Washington Post, April 27, 1949]

COST OF MEDICAL CARE

Chairman Elbert D. Thomas of the Senate Committe on Labor and Public Welfare candidly says that it is impossible to estimate how much it will cost to pay for the medical and hospital service to which the public would be entitled under the administration's health-insurance bill. It is reasonable to surmise, however, that it will cost more than the Government is now planning to spend. A worker earnings $2,400 would be taxed $36 a year. A tax of equal amount would be paid in his behalf by his employer and the Government would add a contribution of $12 for each of the first 3 years.

In other words, a total of $84 a year would go into the insurance fund in behalf of the $2,400-a-year worker, and twice that sum in behalf of a worker with twice that income. In all cases the worker and members of his family would be entitled to complete medical, hospital and dental care, including eye glasses, hearing aids and so forth.

If $2,400 may be roughly regarded as an average income, it is difficult to see how $84 could be stretched to cover so many benefits for a breadwinner and several members of his family. The unfortunate fact is that the average family now obtains only a fraction of the medical, dental, and hospital care that it ought to have. Under a system in which these important services would become the right of everyone, demands for medical care would expand enormously. Appropriate emphasis has been laid on the fact that the country does not now have the doctors, dentists, nurses, hospitals and clinics to render such complete service. It is also important to investigate whether there would ever be any hope of providing full medical care at the cost now contemplated.

Sponsors of the compulsory insurance bill seem to take it for granted that complete health care can be provided to all the people for little more than adequate care for some of the people now costs. That seems to us a basic fallacy. Indeed, complete physical examinations once a year for all members of an average worker's family are likely to cost more than he would pay into the system. Such examinations are unquestionably desirable as the starting point for shifting medical care from an emergency to a preventive basis. But examinations along with hospital care and doctors' calls are expensive, and we doubt that they can be made less so by collecting insurance premiums in the form of taxes. Certainly this is a point that demands thorough exploration by the subcommittee to which the health insurance bill has been referred.

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THE PATIENT'S DILEMMA—EVERYONE IS FOR BETTER HEALTH, BUT THE CHIEF QUESTION IS: CAN THE UNITED STATES GOVERNMENT PROVIDE IT FREE?

(By Greer Williams)

Every man who has faced a serious illness in his family on a salary of $3,000, $5,000, or even $7,000 a year wishes it were possible to have all needed medical attention and hospital care without so much financial sacrifice. He wouldn't care if it meant having the Government take over the doctors.

This may happen.

A bill now before Congress would, its backers lead us to believe, bring us complete medical care at low cost, and for 100 percent of the population in 10 years.

The bill provides for a national health insurance to be financed by a pay-roll deduction, the same as social security and withholding taxes, plus supplementary appropriations from general tax funds. The deductions would be about 4 percent on the first $4,800 of salary, the employee paying one-half and the employer contributing the other.

Of course, you have heard of compulsory health insurance before—just as you've probably heard of the Blue Cross and Blue Shield voluntary insurance plans and of commercial health and accident policies. The bill, introduced in both Senate and House of Representatives, is the latest of the Wagner-Murray-Dingell national health series—with Senator McGrath's name now thrown in.

A compulsory-sickness-insurance bill has been introduced in every session of Congress for the past 30 or 35 years. Hence, the new one would hardly be news were it not for President Truman's happy ability to stump the experts and impress Congress that he knows his politics. The President repeatedly has asked for this piece of legislation.

This year, some of the bill's opponents, such as Dr. Paul R. Hawley, give it a chance of coming to a vote for the first time. Hawley, famed as the GI's doctor during the war and Veterans' Administration medical director for 2 years afterward, is head of the Blue Cross-Blue Shield Commission. This is a combination of the nonprofit insurance plans sponsored by the voluntary hospitals and by organized medicine.

These plans provide hospital benefits for 28,000,000 persons and medical benefits for some 7,000,000. As the result of a phenomenal growth in the past few years, voluntary insurance in both nonprofit and commercial forms today covers more than 52,000,000 Americans with either a service or cash-indemnity type of protection against certain sickness expenses.

"If the voluntary insurance people are making headway," the reasonable man might ask, "is it necessary for the Government to push in, as a third party, in the relationship of doctor and patient? Should the Government hold the stake?"

DISSECTING OUR HEALTH

Federal Security Administrator Oscar R. Ewing says it should. He agrees that voluntary insurance "for the most part has done an excellent job," but claims that it it too limited in the diseases and the people it can cover. What he wants and expects of health insurance is described in his September 1948 report to the President, The Nation's Health, a 10-Year Program, which embodies Mr. Truman's plan.

Certainly, every American can find his own wish for better health attractively packaged in the Ewing report. Among its proposals are Federal aid in training more doctors, in building more hospitals, in extending public health into neglected localities and in developing child-health and mental-health programs. In 10 years, Ewing hopes that we will be spending $4,000,000,000 annually on such activities.

His key proposal, however, is for compulsory health insurance. He estimates it would cost $4,000,000,000 to $6,000,000,000 a year in pay-roll taxes and might use general revenue to supplement its contributions, as necessary. Such a fund, he says, would pay your bills for the costs of doctors, hospitals, nurses, dentists, drugs and appliances and make "comprehensive" and "adequate" care accessible to all, as rapidly as possible.

"The prime objective," says Ewing, "would be the improved health of the people."

He estimates that 325,000 persons now die each year who could be saved if they had the benefit of modern health and medical services. He is convinced, he says, that there is no other way of preventing these and other losses in health and wealth.

The doctors—whose task it would be to prove him right should we have a compulsory system—disagree with Ewing. He admits that the majority of physicians as well as their American Medical Association leaders oppose national health insurance.

"But," he asks, "which is more important, the interests of 190,000 doctors or the health of 68,000,000 persons who cannot pay for adequate medical care?"

Is it true, as the layman is readily led to believe, that the medical profession opposes Government control of the patient's dollar purely for selfish reasons of profit? The private-office practitioner is, of course, a businessman as well as a professional man engaged in "service above self." He is entitled to some financial as well as spiritual rewards. He assumes life-and-death responsibilities, and may work 60 to 80 hours a week.

I have talked to scores of doctors, many of them devoted to their patients.

Their case against compulsory health insurance boils down to three points:

1. It will not make medical care better, but worse.

2. It is not insurance, but a waste of money.
3. It will not reduce sickness or save lives.

In the first place, they say, the patients would swamp them if people could run to the doctor without having to count the cost. We get reports on how the British are standing in line to see doctors since Great Britain put its free and universal National Health Service into effect last July. One doctor, after a busy day, contemplated the stack of certificates he had to sign for free drugs, free hot water bottles, free baby food, free artificial limbs, coal, gasoline, milk and eggs.

"The greatest aid to medical science ever invented was the ball point pen," he said.

Even Ewing's opposite number, Health Minister Aneurin Bevan, was dismayed. Much of the population, he remarked, had developed bad eyesight.

"FREE" SERVICES ARE ABUSED

"Because things are free is no reason why people should abuse their opportunities," scolded Bevan, possibly forgetting his elementary phychology on what happens when "the other fellow" pays.

But the United States is not Great Britain. Americans have more money and less patience. We don't object to getting something for nothing, but we still want service. Even now, patients complain that doctors keep them waiting and then don't give them any time.

In modern diagnosis, despite all the apparatus, there is still no substitute for the time it takes a careful doctor to question and examine a patient. It also takes time to build up the patient's confidence and allay his fears. One doctor who went to work in a Government clinic after the war quit in disgust 3 weeks later. He discovered two brain tumors, previously overlooked, but it was made clear to him that the big problem was to move a large volume of patient's and their records.

Then, as every ex-Army doctor knows, there is the problem of the "goldbrick."

Ewing concedes that we haven't enough doctors to meet the demand at the outset.

A shortage of doctors, however, was not the source of difficulty in San Francisco's experiment with compulsory health insurance. This city, described by one doctor as a "beautiful guinea pig," provides the only good laboratory test that we have on how things go under a compulsory system promising medical care at low cost.

In 1937, San Francisco voters—at another time when there was considerable agitation for medical as well as social security—approved a city charter amendment sought by municipal employees. This required some 12,000 of them to contribute to a municipal employees' health service system, later nicknamed HSS. The employees elected a board of directors and hired a medical director.

The board manifested a distrust of doctors and their fees from the first. But the doctors, most of them members of the San Francisco County Medical Society, overcame their own doubts and decided to go along. About 1,000 of the city's 1,250 joined the HSS panel. The board decided that pay-roll deductions would be $27 a year per adult—$72 for man, wife and child.

In return, HSS members were entitled to the home, office and hospital services of a physician of their own choice day or night—the same as you would under national health insurance. But hospitalization was limited to 21 days a year. Other limitations were imposed—as Ewing grants might be necessary at first under his scheme.

Having babies was the employee's own lookout, the board ruled. Victims of a list of conditions including veneral disease, alcoholism, mental disease, and tuberculosis were not entitled to hospital care. They would remain solely public institutional problems. The pay-roll tax was HSS's only source of funds and it had to pay administrative overhead and stay within those funds. It couldn't do it.

DOCTORS' FEES REDUCED

The doctors were paid on a unit system—five units for an office call, 125 units for an appendectomy and so on. A unit had a $1 par value. Despite the limitations imposed, the costs of services rendered rapidly exceeded available funds. To make up the deficit, the fee unit was successively reduced until the doctors found themselves working for 50 cents on every dollar charged. The Medical Society complained that HSS should further limit its benefits to its members or increase their premiums.

The HSS medical director publicly accused the doctors of sticking their heads in the door of a patient's room and charging for a call—three units. A similar accusation was made again some doctors during the old days of Federal relief. When their fee for treating a relief client was reduced from $1 to around 50 cents, because of a shortage of funds, they doubled their calls! They had to live, too.

After the HSS board had agreed to a new fee schedule and then reneged, almost the whole panel of doctors threatened to resign in 1941. The municipal employees then formed a Health Service Protection Association—seemingly to protect themselves against their protectors—and elected a new board the next year on the slogan. "Put the Fee Schedule into Effect."

Then, for the first time, an actuarial analyst was called on for advice. He found that in four years the doctors had been paid $400,000 less than the fees agreed upon. In other words, they had been giving city employees charity on a percentage basis and keeping HSS alive by absorbing its deficit. The hospitals always had been paid in full.

Reforms were instituted. The single adult premium was hiked to $33 a year. Restrictions were placed on the great amount of medical care for elderly, chronically ill dependents. For a time, everything went fine. The departure of 400 doctors for war, of course, put a patriotic crimp in services asked and given. After the war, HSS members, now numbering around 17,000 discovered that they had a load of neglected ills.

IN THE RED AGAIN

The rush was on again. In 1946, San Francisco's compulsory health system—hailed by health reformers as a splendid example of what they wanted nationally—decried by "aginers" as a horrible example of what happens when a third party comes between doctor and patient—was running $3,000 a month in the red.

The doctors made two requests for a 15 percent fee increase to meet rising costs. The board tabled the first and took 90 days to reject the second. The doctors were down to 80 cents on a prewar dollar unit when the board in 1947 raised the premium to $40.50.

Then, in May, Dr. Alexander S. Keenan, the medical director, wrote each panel doctor a letter. In 1 year, he said, expenditures for office calls had gone up 20 percent; for laboratory tests, 34 percent; X-ray examinations, 65 percent; hospitalization, 87 percent. The patients were demanding too much service, he ruled, and the doctors were giving them too much.

He said that municipal employees were seeking treatment for trivial things, "treated as well by their home remedies."

Dr. Keenan requested his medical fellows to "make a diagnosis without leaning so much upon the laboratories and the X-ray departments." Surveying X-ray records for those revealing diseases, he said, "I feel safe in saying that between 50 and 60 percent are unnecessary."

The panel doctors hit the ceiling. They protested that no one was going to tell them how to practice.

Dr. Anthony B. Diepenbrock, then Medical Society president and a panel doctor, wrote a letter to the HSS board. He condemned the Keenan directive as an attempt to "deny adequate medical care to the sick" and an admission that the system was "actuarially unsound."

Horrified at the home remedy suggestion, Dr. Diepenbrock found himself on solid ground, it appeared, in defending the type of comprehensive diagnosis which compulsory health insurance advocates say should be put within reach of all. If from 50 to 60 percent of the X-rays were negative, observed the indignant doctor, then apparently 40 to 50 percent did reveal disease. Could the doctor tell in advance which would be negative?

Another "let's resign" movement spread through Medical Society ranks and, in November 1947, after HSS had stalled off settlement of the dispute, more than 900 doctors walked out The "striking doctors," as enemies called them, announced that they would treat municipal employees on a private basis. The Medical Society guaranteed none would lack adequate medical care through inability to pay. "The experiment has failed," said Diepenbrock.

The HSS fate is still unsettled. Established by law, it is now involved in a court fight over how it shall operate.

What are the lessons of the San Francisco story?

One seems to be that a compulsory system doesn't solve all your medical problems. It introduces new ones. People figure that if they are paying for service anyway, they ought to get their money's worth. Doctors refuse to accept responsibility for their patients and outside dictation, too. Dictation of how much and what kind of service they my give follows, however, when the administration's original demand for more adequate medical care results in a deficit and a countermand for less.

Jay C. Ketchum, executive director of the Michigan Medical Service, says it is impossible for either voluntary or compulsory insurance to offer comprehensive medical care at low cost and still remain solvent. This was learned the hard way by the Michigan Medical Service, the largest voluntary prepaid medical care group in the country, with 1,300,000 subscribers and ten years' experience.

The Michigan group tried to insure full medical care to workers with salaries up to $2,500, beginning in 1941. At $54 a year per family, the group ran itself more than $700,000 in the red in 2 years. There were only 4,400 subscribers, but they got almost twice as much medical care as they paid for. The group used accumulating reserves from its limited contracts to bail itself out during the next couple of years, and swore never again.

A voluntary contract limited to surgery and obstetrics, two of the biggest and most common medical expense headaches, now may be had in Michigan for $27 a year. An additional $12 will cover the family for medical care during hospitalization. Meanwhile, the Michigan Blue Cross hospitalization insurance offers a family 120 days' full coverage for each disability at $48 a year. Maternity cases are accepted after the first 9 months' membership, and mental or tuberculous patients are allowed 30 days in a general hospital.

Recent computations, Ketchum said, show that it would cost about $180 a year to prepay full medical care for Detroit families earning up to $4,000—or $228 including Blue Cross hospitalization. That's nearly 6 percent of a $4,000 income. He doesn't regard this as insurance, but a sort of medical budget plan. He believes it is too high to attract many takers. Ewing offers the same package for $160 a year in his scheme and throws in dental and home nursing care, drugs and appliances.

WILL RUN AT DEFICIT

A business man might wonder how the Government could do it. Ketchum's answer—and Hawley's too—is that the Government can't—not without running up a big deficit. Ewing has provided for deficit-financing out of general appropriations, but nonetheless sees his plan as resting upon insurance principles which have been part of our national fabric for generations.

Hawley has challenged this as a piece of deception. National health insurance is not insurance, but a form of socialized medicine, he says. Ewing denies this.

Ketchum regards national health insurance as merely tax-paid medical care superimposing a fictitious insurance superstructure on a charity base. The basic requirement of insurance, he said, is that penalties equal benefits. As the sees it, dropping into the doctor's office to have your throat swabbed or your heart checked is not an insurable loss.

All right, you might say, maybe national health insurance isn't really insurance and will annually cost the Nation not four or six but X billions of dollars, but wouldn't it be worth shooting the works to improve our health and make us live longer? This, after all, is Ewing's big selling point.

Hospital and medical authorities, in reply, mention certain economic and scientific realities. For one thing, insurance offers no solution for the treatment of mental disease, tuberculosis or other chronic, disabling and financially exhausting illnesses. Such conditions may require 6 months, a year, or 2 years in the hospital at a huge cost per patient.

CHRONIC ILLNESS A PROBLEM

The recovery or rehabilitation of the chronically disabled, therefore, would remain as it has in the past—a problem of increasing public support for free hospitals.

Included in this type of health break-down are many who are stricken with one of our five leading killers—heart disease, cancer, brain hemorrhage, accident injuries, and kidney diseases. Ewing claims that national health insurance would save a great many who die of these diseases.

By this he means that such persons would then be able to afford examinations early enough and often eough so that the doctors could catch their troubles in time to do something about them.

But the trouble in San Francisco, as we saw, was that the compulsory system could not pay the expense of comprehensive examinations and hence ordered the doctors to cut down on them. There are limits to what Uncle Sam can spend, too.

Testimony on a previous Wagner-Murray-Dingell bill brought out that, if every doctor worked 60 hours a week, 50 weeks a year, each of us would annually be entitled to about 4 hours of a doctor's time. This would be enough for a careful physical examination for each of us, but would allow the doctor no time for treating the sick!

The health reformers' reply to that is that we can train more doctors to meet the increased demand. Again, we run into limitations, and this time unpleasant ones.

Take heart disease, the No. 1 killer. Doctors can get the best medical care in the world without charge, on a professional courtesy basis, and yet they have a higher heart death rate than the rest of us.

Take cancer, the No. 2 killer. Stomach cancer takes the highest toll among the various types of malignancy. Two Mayo Clinic radiologists, Drs. B. R. Kirklin and John R. Hodgson, recently stated that mass X-ray detection of stomach cancer in its early, treatable stage was "impossible." They listed several cancer specialists who failed to recognize the disease in themselves until it was too late.

Take brain hemorrhage, the No. 3 killer. President Roosevelt, under expert medical observation for years before his death at 63 died of brain hemorrhage which his physician, Admiral Ross T. McIntire, stated—with ample support of medical opinion—"was and is unpredictable."

Take accident injuries, the No. 4 killer. Ewing charged up 40,000 annual accident deaths to inadequate health and medical services, and Dr. Morris Fishbein, A. M. A. Journal editor, challenged him to show the National Safety Council how they could be prevented, or even "that any considerable number died without medical attention."

Take nephritis the No. 5 killer. Quoting the 1836 lament of Dr. Richard Bright about the lack of adequate treatment for the kidney disease named for him, Dr. Russell L. Cecil of Cornell University observes, more than 100 years later, "We today, cannot cure the disease."

COLD LOSES MOST TIME

For that matter, take the common cold. Dr. Gilson Colby Engel, Pennsylvania State Medical Society president, cited Ewing's statement that the Nation loses 4,300,000 man-years of work each year due to bad health. This, Engel protested, is hardly an argument for a national experiment with medical care since time lost due to sickness already has been reduced from 27 to 5 days per worker in the past 40 years. "The majority of these workdays lost are due to the common cold," he said. Staying home in bed is still about the most adequae treatment doctors can recommend for a cold.

Th plain, simple fact is that medical science does not as yet have the cures, skills, tools, the men and the magic to make the Ewing health dream come true. Grant the difficulty in distinguishing between the doctor's material and spiritual motives for fighting Government invasion of private medicine. Grant all their failings. They still have logical basis for arguing that compulsory health insurance won't help you, the patient. They have evidence that it might even hurt you.

Considering Ewing's lack of proof to the contrary, he appears to have made a pretty good case—for the doctors.

[From the Congressional Record, April 26, 1949]

Views of Mr. Herbert Hoover on Social Security

New York, N. Y., *April 25, 1949.*

The Honorable Robert L. Doughton,
Chairman of the Ways and Means Committee,
House of Representatives, Washington, D. C.

Dear Mr. Congressman: I beg to acknowledge your request that I make some comment on H. R. 2893 and H. R. 2892 which relate to revision and expansion of Federal Old-Age and Survivors' Insurance and the Federal-State public assistance programs.

The following notes relating to the systems existing at present are based upon data collected by the Commission on Organization of the Executive Branch. That Commission did not deal with policy question to be determined by Congress. The views on policy expressed herein, therefore, are solely my own.

I wish to say at once that I strongly favor governmental provision for protection of the aged and their dependents.

The problem before the Nation is to obtain a workable system, with a minimum of administrative cost, a minimum of bureaucracy, adjusted to the economic strength of the country which gives an assurance of security to this group. In my view, we have not yet found that system.

I should like to make two general observations:

1. There is an illusion about the whole Federal Old-Age and Survivors' Insurance. Because the taxes on pay rolls are paid into a trust fund and paid out without appropriation by Congress, there is an idea that these are neither taxes nor Federal expenditures. They are just as much a burden upon our national economy as any other tax or any other Government expenditure. Also, pay-roll taxes, however justifiable, are, like all other taxes, a burden on the standard of living of the whole Nation. A considerable part of the pay-roll taxes paid by employers in the long run is passed to the people as a whole in prices, and a considerable part of the taxes paid by wage earners is passed on by demands for increased wages.

2. There are many desirable things that every American home would like to have, but its income compels it to deny itself, at least temporarily. It is similar with the Nation.

Since this legislation was originally passed in 1935, we have increased the total burden of Federal expenditures from about $9,700,000,000 a year to a prospective $45,000,000,000 a year, included in which are about $23,000,000,000 for defense and European aid—most of which constitutes the cost of the cold war.

Already our economy is up to the limit of endurance under this load. I believe we should go slow and hold further additions to this burden to the absolute minimum. When the cold war is over, we can afford many more domestic improvements.

I can find no satisfactory estimates of the cost of these two proposals if enacted into law. There would be, however, a huge increase in the tax burden on our economy from this legislation. I make some tentative estimates later on.

THE PRESENT SYSTEM

1. The old-age problem has been thrust upon the Federal Government largely by the great increase in longevity. Its dimensions are indicated by the fact that there will be by 1950 about 11,000,000 persons over 65 years of age. They will increase in numbers absolutely and relatively, both with the increase in population and with the constantly advancing protections to health.

2. The Nation today is undertaking to solve the problem from three different directions:

First is the joint Federal-State assistance to which I shall refer as "State systems." Forty-eight of the States and three other jurisdictions, with Federal aid, give old-age assistance, dependency, children's benefits, and other social services, based upon individual needs. The variations in the needs requirement are considerable, and in a few States are so liberally interpreted as to be practically universal old-age pensions. The total number of persons given assistance by the State systems is about 2,300,000.

The average amount of payments to the aged in need in all 48 States is $42.02 per month per person. In the 46 most typical States based on need, the average payment is about $39.50 per month per person. These monthly payments vary greatly among the States—ranging from a low of about $20 to a high of about $78 a month in one State. The annual cost averages about $1,200,000,000—about one-half of which is paid by the States and about one-half by the Federal Government.

Second is the Federal old-age and survivors' insurance, based upon pay-roll taxes, to which I shall refer as the "Federal Insurance System." Benefits are now being paid out to about 2,260,000 persons at an annual cost of about $556,000,000, and averaging about $25 per person per month, including their dependents. The payments being insufficient for the needy, many must be supplemented by the State systems.

Third is a multitude of old-age pension and retirement systems in the country extend into the 65-year-age group: Federal civil-service retirement systems; the to which I shall refer as the "independent systems." They are in the main Federal veteran and military pensions and disability systems of this group which extend into the 65-year-age group: Federal civil-service retirement systems; the Railroad Retirement System; the old-age or retirement systems of the States and local governments; the old-age or retirement systems of universities, hospitals, fraternal organizations and other benevolent institutions, insurance companies, businesses, and industries. There is now a new form of old-age and retirement system emerging in particular industries as the result of collective bargaining. These systems together with pensions to veterans, bid fair to be further extended.

The number of persons now receiving pensions or aid from these independent services is estimated at about 2,300,000. The monthly payments under these systems are much higher, on the average, than the other two systems.

Theoretically, there are about 7,000,000 persons now receiving benefits from all three systems. This, however, includes dependents less than 65 years old and there are duplications because in many cases the benefits from the Federal insurance system are inadequate and must be supplemented by the State systems.

FAULTS IN THE PRESENT FEDERAL INSURANCE SYSTEM

3. There are serious faults in the Federal insurance system.

(*a*) The original concepts, as embodied in the Social Security Act of 1935, were that the money to pay for the benefits would come from employees and employers by a tax on pay rolls, and that the system would be self-sustaining. The original actuarial basis of the system was faulty and was made worse by the legislation of 1939.

One of the methods of this system contemplated building up a reserve fund in the early years to compensate the subsequent increased benefits. The moneys collected from the pay rolls have been, and are at present, in excess of the payments to beneficiaries, and the trust fund of about $10,000,000,000 has been accumulated and invested in Government bonds. The growth of expenditures for benefits under the present act apparently will exhaust this reserve in from 5 to 10 years, and the general taxpayer will be forced to make up the annual deficit. This deficit, it is estimated, will rise ultimately to about $1,700,000,000 per annum.

(*b*) An additional burden, however, is thrust on the general taxpayer. Under the present system the Federal Government has used the surplus income of the trust fund (amounting to the $10,000,000,000) for its current expenses and placed its I. O. U. (in the shape of Government bonds) in the trust fund for the money thus used. It is estimated that the benefits paid out will begin to exceed the receipts (upon the present basis of the pay-roll tax and benefits) in a few years. When this occurs, the Government must dedeem its I. O. U.'s from the trust fund. The money to redeem them must come from the general taxpayer. Even if the bonds were sold to the public, ultimately they must be redeemed by the taxpayer. As those who have already paid the pay-roll deductions are also taxpayers, they will, to some extent, be paying for their insurance twice over.

I cannot agree with the economic arguments before your committee which are to the contrary. The simple fact is that the money has been raised by a tax, and except for benefits already paid, has been used as current expenditures by the Government, and must be replaced from somewhere—the taxpayer.

THE PROPOSED NEW LEGISLATION

4. I do not have the technical staff to analyze in detail the effect of the amendments to previous legislation implied in these two bills (H. R. 2893 and 2892). However, I make some over-all observations which may be worthy of consideration by your committee.

(*a*) I suggest that the committee consider abandoning the whole reserve fund concept and that the Federal Insurance System be put on a pay-as-you-go basis. It should be no more difficult to calculate for a year ahead the amount of pay-roll taxes required to meet the outgo than any other taxes. The present reserve fund of $10,000,000,000 could remain as a balance wheel. It could be drawn upon temporarily when advanced calculations of the tax prove inadequate and then could be restored the following year. This procedure would enable the Congress to fix the tax as needed and to appropriate the budget annually. In the latter matter, it has no voice at all at present. Such a method of pay and collect as you go would avoid the faults pointed out in the paragraphs 3 (*a*) and (*b*), above.

I am aware it will be contended that this course would deprive the scheme of its purported actuarial basis. As a matter of fact it has been abandoned under the present system. But more important, the basic fault of double payment by beneficiaries (3 (*b*), above) destroys all such actuarial contentions anyway. And the same situation will apply to the new legislation as it again proposes to increase reserves, and spend the increased money for current expenses of the Government, with ultimate replacement by the taxpayer.

(*b*) To visualize what the plans under H. R. 2893 and 2892 mean, it is necessary to reduce them to some sort of figures. It is proposed in H. R. 2893 (Federal insurance system) to increase the taxes on pay rolls, which now amount to about $1,700,000,000 per annum, to about $4,800,000,000. Obviously, this is an increase in tax burdens by about $3,100,000,000 per annum at once.

As I have said, I can find no adequate estimates of the annual expenditures under these two bills. Some estimates of the costs of adopting H. R. 2893 (Federal insurance system) are given, but apparently they do not include all of the features in the bill. I have found no estimates of the cost of the additional grants-in-aid to the State systems under H. R. 2892, or of the other direct expenditures implied in that bill. They are, apparently, large.

The estimated Federal insurance system expenditures under H. R. 2893 alone are:

Present expenditures	$556, 000, 000
1950	1, 750, 000, 000
1955	3, 400, 000, 000
1960	5, 900, 000, 000

(These figures as to H. R. 2893 are about halfway between the high and low estimates furnished to the committee.)

The very large increase in Federal expenditures is obvious. Moreover, it is also obvious that the reserve fund, in the next 10 years, would be greatly increased. This surplus of pay-roll taxes over the benefits paid out again is to be represented by more bonds and used for current expenses—and ultimately the general taxpayer will pay a large part of the bill.

As a method of increasing Government revenues, it is a tax on the lowest incomes in the country—provided they do not secure an increase in wages to compensate. In such case, however, it falls on the consumer, of which these beneficiaries are the largest group.

The answer to all these dilemmas is to abandon further building of the reserve fund and to put the whole business on a collect-and-pay-as-you-go basis. If my proposal were adopted, even the present pay-roll tax burden could be reduced during the next critical years.

(*c*) Aside from the faults inherent in the Federal insurance system, the ultimate result of this new legislation will be to absorb or extinguish much of the independent systems. The independent systems should be maintained and encouraged. They represent a flowering of American freedom and of moral growth. They have more efficient administration and usually provide greater benefits to their members than do either the Federal insurance system or State systems. In the few instances where, by a change of jobs, a small number of beneficiaries under the independent systems might lose all or part of their rights under these systems, they can be picked up by the State systems.

(*d*) Another point worth noting is that the powers vested in the Federal Administrator under these two bills could go a long way to extinguish the independence of the States in welfare activities. This can also result in an enormous increase in the number of State, Federal, and other public officials necessary for administration. There are probably 30,000 State and Federal officials already engaged in administration even now.

A COURSE OF ACTION

5. My own opinion, having regard for our obligations to prevent suffering by the aged and their dependents due to the increased cost of living, together with the difficult economic situation we face from the cold war, is that we should go slowly and proceed as follows:

(*a*) The further expansion of reserve funds should be abandoned, and the system should be placed on a pay-as-you-go basis.

(*b*) Increase the coverage of the Federal insurance system but, for the present, undertake none of the other expansions proposed in H. R. 2893 and thus greatly reduce the expenditures required.

(*c*) Develop the State systems based on need by further Federal grants to provide more adequately for the aged and dependents actually in need (the average now being only $42.02 per person per month, with some States as low as about $20 per month), and to enact none of the expansions in H. R. 2892.

The real and urgent problem is the need group. It is not solved now, nor can it be solved for many years, by the Federal insurance system—even if that system can be made to work efficiently.

Whatever increased cost may be thus required in taking care of our needy and aged, it could be covered many times over by adopting the recommendations for better organization of the executive branch proposed by the Commission.

SEARCH FOR A SIMPLER SYSTEM

6. The committee, in my opinion, should undertake to establish an independent research body to provide analyses of other possible systems. It should be given a year for study.

The reasons are:

(*a*) On the organizational side both the State systems and the Federal insurance system maintain expensive administrations of the same general problem. The administrative cost of the Federal insurance system is likely, under this bill, to rise eventually to over $100,000,000 per annum. The independent systems do not overlap so extensively in the administration field, and usually are managed more economically.

(*b*) In the financial support of these three systems the overlap is very great. Many of the independent systems and the Federal insurance system are based upon pay-roll contributions, and thus many contributors are in both systems, are being twice insured, and will receive benefits from both systems. The people do not need to be provided for twice over, and where they are in both systems their deduction burdens are very great and a menace to their families' standard of living.

(*c*) It is obvious that the State systems must be maintained for many years to come. It would be many, many years before complete and adequate coverage and benefits could be attained by the Federal insurance system. Its benefits, even under the new bill, are inadequate in many instances, and must, in any event, be supplemented by the State systems based upon need.

(*d*) A careful inquiry might disclose an entirely different system which would avoid the huge costs of administration and the duplication, which would substitute some other form of taxation, more simple and more direct for its support, and which would give more positive security to the aged than this complicated system.

It is worth looking into.

I attach hereto the pages of the Report of the Commission on Organization of the Executive Branch of the Government, and those of our task force (the Brookings Institution), which relate to some parts of this subject.

Yours faithfully,

HERBERT HOOVER.

[Editorial from the Saturday Evening Post, July 16, 1949]

ENGLAND FINDS FREE RIDE AIN'T NECESSARILY SO

Not so long ago, people interested in the improvement of social conditions assumed that progress was inevitable. Everything would get better and better indefinitely, as more and more activities passed into the unselfish hands of Government officials.

The measure of an advanced civilization, under this plausible theory, was taken by noting how far it had gone down the road to state control. This, of course, was in the days before the new totalitarians gave us a glimpse of what paradise on earth could mean in terms of hell for the individual.

Still, there was the track, and the well-meaning liberal could identify the position of the entries in the Happiness Stakes. On his form sheet, Uncle Sam was floundering far in the rear, at least 30 lengths, or 30 years, behind leaders like the Continental countries and Great Britain. Social reformers constantly reproached Americans for being so laggard in adopting the "social" point of view.

What looked like a misfortune a decade ago may turn out to be a lucky break, as we look over the results of the race for a managed economy and a managed society. Instead of using whip and boot heel to catch up on the front runners, we might do well to sit back and see whether it's worth while.

To cite one example, consider the move for a national compulsory health plan. In some quarters it is taken for granted that this is a good thing; that it must come sooner or later, and that everybody will benefit by it. For proof, they say, see Britain.

The budget speech of Sir Stafford Cripps earlier in the spring throws some interesting side lights on British experience.

He said, "Last year the people of this country enjoyed an unexampled national dividend in the form of free national health service at the cost, for 9 months of its duration, of £208,000,000." (An honorable member: "Free?") "Free to the individual. Next year, for 12 months, it is estimated to cost £268,000,000."

A little further on, he pointed out that total taxation in Britain, local and national, was now more than 40 percent of the national income. At that level, the redistribution of income entailed in the payment for social services already fell, to a considerable extent, upon those who were also the recipients of those services. In other words, the people were paying for what they were getting, although they had been sold on the idea that it was free.

The trouble is, from the Government's point of view, that it is now becoming hard to convince the voter that the service is not free at all. How can they break this sad news? How can they show him that you can't just barge into a doctor's office and order everything in sight? Sir Stafford thought a price tag might help.

"There was, indeed, a very good argument," he said, "for imposing some special charge or tax in connection with the health services, both to help finance them and to bring home to people generally the simple fact that they had to be paid for out of taxation. It was argued, with some force, that this might help to make people more economical in their use of the services."

But, on the whole, according to the report in the London Times, he had come to the conclusion that they should await the outcome of another year before taking action. By that time, presumably, another election would be out of the way.

A good deal of the Labor Party's legislation in the last 4 years amounted to action as irreversible as going over Niagara Falls in a barrel. The health plan, no matter how unwisely framed, is now considered politically untouchable. Before we get involved in any similar efforts, it may pay us to kibitz for a while.

The Issue of Compulsory Health Insurance

(Paul R. Hawley, M. D.)

Except for the addition of a small amount of material which did not become available until later, this is a speech delivered to the Economic Club of Detroit on March 14, 1949.

(Blue Cross Commission—Blue Shield Commission, Chicago, Ill.)

It is a great mistake to consider compulsory health insurance as a separate, discrete issue in our present political situation. Compulsory health insurance is only a part of a large program designed to remake the United States into a Socialist state.

Since the Socialist Party has achieved no political success to speak of, after years of existence in this country—and the Communist Party even less, although the success of the Communists in other directions is rather startling—our radical thinkers have turned to the popular political parties for the implementation of their program. This political maneuver offers them two great advantages. First, it removes the Socialist label from the program, which would be offensive to the majority of Americans; and, second, by dangling the left-wing vote before the greedy eyes of certain politicians of the established parties, it bribes them into incorporating the radical program in their platforms.

When viewed objectively and broadly, compulsory health insurance is no more vicious than a number of other "gimme" projects in the Socialist program—and it may even be less dangerous than some. Much of its importance arises from the fact that, because of its emotional appeal, it is being used as the spearhead of this drive toward the Socialist state. Like Mr. Coolidge's preacher, who was "agin sin," our people are opposed to suffering and death. Their generous responses to appeals in behalf of the distressed peoples of the world are a measure of the softness of their hearts. They are peculiarly susceptible to propaganda devised to exaggerate deficiencies in our social structure. They are a credulous people, unwilling to impute false motives to schemers, whether the schemers be individuals or nations. Being pitifully uninformed in the field of health, they are in danger of being made suckers by a group who have political axes to grind.

It would be ridiculous to assert that there are no problems in the field of the economics of medical care. For the past 15 years, these problems have become increasingly pressing. The only area of controversy is that of the proper solution of these problems.

As has been the history of social problems for more than a century, all solutions proposed lie between the two extremes of wholly voluntary effort, on the one hand, and the most totalitarian form of socialism, on the other hand. This is the present status of the issue of compulsory health insurance in this country—unless one wishes to recognize that unfortunate, small group of reactionaries who have, thus far, refused to admit the existence of any problem.

I should like, at the outset, to make my own position clear. I have no personal stake in this battle. I am no longer in the practice of medicine and I shall never again return to it. I have no interest in maintaining an attractive economic status for practitioners of medicine except as this is an incentive for better practice and for the best type of young men to choose medicine as a career. My present position as the executive head of the great voluntary nonprofit plans is not at stake for the reason that I have no intention of continuing hard work even as long as it would take to get conpulsory health insurance in operation if the bill were passed at this session of the Congress. So it cannot possibly make any difference to me personally whether we have compulsory health insurance or not.

THREAT TO QUALITY OF MEDICAL CARE

However, I have long had an intense interest in improvement of the quality of medical care; and I think I may add, with complete modesty, that I have exerted some small influence toward the improvement of medical care for millions of Americans. I resent bitterly any proposal which will threaten even the present quality of medical care—not to speak of its future improvement. I have seen medicine practiced under free enterprise, and I have seen it practiced by the Government. I consider myself a much more competent judge of medical care than Mr. Ewing and his left-wing cohorts.

In addition, I am an American citizen who was raised in the belief that the American pattern of individual freedom and of free enterprise in democracy is a heritage purchased by the blood of my ancestors who fought in the War of Independence, and that I am unworthy of that heritage if I fail to defend it against the invasion of socialistic and communistic ideologies. I was taught to believe that dignity is an admirable and a desirable quality of mankind; and that the maintenance of human dignity lies largely in man's determination to provide for himself and his dependents instead of demanding charity either of his neighbor or his government.

Our people are now appalled by the disclosures of the infiltration of Communists into high places in our Government. This may throw some light upon the origin of some of the propaganda now being broadcast by the Federal Security Administration. In an address to a Communist Congress in Moscow in 1930, Comrade Manuilsky, who was at the time Secretary of the Communist Internationale, said: "In the United States, for instance, the Communists must launch a powerful movement for social insurance. They must place themselves at the head of this movement and lead it to victory." Manuilsky went on to explain that the principal objective of this world-wide drive for the socialization of medical care was "to strengthen the sections of the Comintern organization." Whether the Communists launched the movement in the United States, or whether they were able to enlist enough fellow travelers to do it for them, the movement was certainly launched. The issue today is whether or not the Communists, or their fellow-travelers, or both, will lead it to victory. That compulsory health insurance is a most important part of the communistic social insurance program was proclaimed by Lenin, himself, who called socialized medicine "the keystone of the Socialist state."

I am no Red baiter. I do not see a Communist behind every telegraph pole—although I am beginning to look closer than I used to, since Communists are now being found in stranger places than that. I am merely presenting this documented evidence that compulsory health insurance is a beloved child of the Communist Party, and that a large part of its support comes from the Communists and their fellowtravelers in this country. Of this, there cannot be the slightest doubt; and it is very important that our people are made fully aware of the antecedents of this scheme.

Early in May of 1948, there met in Washington the National Health Assembly, called by the Federal Security Administrator ostensibly for the purpose of making an objective study of the adequacy of our national resources in the field of health care. The fact that, in the report of the Federal Security Administrator to the President in a printed public document entitled "The Nation's Health," agreements reached in the National Health Assembly are so cleverly interlaced with the Marxian ideology of the Federal Security Administration that only an astute reader, alive to the situation, can distinguish between them, should not be permitted to blind us to the deficiencies in our health programs. It is a natural reaction to discredit an entire document when obvious propaganda, bearing only an obscure relation to truth, is encountered in it.

CALCULATED DISTORTON OF FACT

For this reason, The Nation's Health is an unfortunate document. Much of its contents is true, and should be pondered by every responsible citizen. On the other hand, many of the accepted facts presented have been, by implication or context, purposely distorted in a calculated effort to convey an erroneous impression to the casual reader; and there are some downright untruths in the document. As citizens, I think we have the right to inquire by what right such propaganda has been published by a Government department at the expense of the taxpayer.

As regards the health program now being advocated by Hon. Oscar R. Ewing, Federal Security Administrator, every reasonable liberal thinker with a social conscience can accept in principle all its objectives except that of compulsory health insurance. I regard compulsory health insurance as an objective of Mr. Ewing and his radical supporters, rather than as a means to achieve an objective, because the proponents of compulsory health insurance have elected to wage their battle uncompromisingly upon this single issue. They will consider no plan for improvement of the health of the Nation which does not include this extreme leap into national socialism.

A large part of the propaganda now being so copiously put forth by people who presumably are supposed to carry out, rather than direct, the will of the people is aimed at the creation of an impression that there is an immediate and urgent necessity for a drastic change in the pattern of medical care in this country. Our traditional pattern of medical care, say the propagandists, has failed to bring to the great majority of our people the blessings to be had from the advances in medical knowledge. "Every year," says Mr. Ewing, "over 300,00 people die whom we have the knowledge and skills to save. This stark fact proves that the present system is inadequate."

Other than to assure you that Mr. Ewing's self-labelled "fact" is not a fact—stark or otherwise—I shall not labor this point. Even if his so-called "fact" were a fact, it would not prove his contention, for the reason that there are millions—not merely hundreds of thousands—of people in this country who, through indifference or negligence, do not avail themselves of the medical care that is now easily within their reach. But this is not the only example of mendacious invention or covinous cant to be found in the arguments of the proponents of compulsory health insurance.

Let us rather inquire into the success or failure of the system of medical care that we now have.

In Rome, in the days of its empire, the average length of human life was 24 years. When I was born, I had a life expectancy of 43 years. (I do not need to assure you that I have long since become a disappointment to the actuaries.) So, the medical progress of 2,000 years, prior to the day I was born, had added only 19 years to the average length of life. This is at the rate of only one additional year of life for every hundred years of medical advance.

My grandson, who was born last year, has a life expectancy of 65 years. Had he been a girl, the chances were even that she would live to be more than 70. During my own lifetime, 24 years have been added to the average length of life (both sexes considered). Six and one-half of these years have been added in the past 15 years. This is at the rate of one additional year of life added every 28 months, instead of every hundred years. So the rate of improvement is still accelerating and the limit of this increase in the average length of life is not yet in sight.

TAX-PAID PILLS NOT THE ANSWER

How much more progress can we reasonably expect? These pseudo-sociologists and Socialists may assure you that, with compulsory health insurance, we shall all live to be 150 years of age; but the biologists, who know a few things about other factors influencing life span, will tell you that there is more to this matter than pills dispensed wholesale at the expense of the taxpayer.

Granting always that there is still room for improvement, it seems to me that we are doing pretty well under our traditional form of medical care. I wonder how many of you would consider completely revolutionizing the pattern of your business if it were making such progress.

Except as a political experiment in a direction which, I hope, is still abhorrent to the majority of Americans, compulsory health insurance would not be such a great evil if it offered any hope of maintaining even the present quality of medical care. Mr. Ewing assures you that compulsory health insurance will not change the present pattern of medical care. Mr. Ewing is a distinguished lawyer who has retired from the law in favor of a political career.

I know nothing of the law, and even less of politics; but I know considerable about medical care. My grandfather was a physician; my father was a physician; I have been a physician for 35 years. It has fallen to my lot to have been responsible for the medical care of millions of Americans. I know what makes doctors tick and hospitals hum. I have never made a truer statement than this one that I am about to make: Compulsory health insurance will lower the quality of medical care in this country to a disastrous degree.

GREAT BRITAIN'S EXPERIENCE

How do I know this? I have only to look at the results of compulsory health insurance in other countries. Let's take a look at Great Britain. Let's forget that it is costing Great Britain considerably more than twice the cost promised by the Socialist government—let's forget, for the moment, its exorbitant cost and see only what it is giving.

Quite a number of people have spoken or written upon the operation of compulsory health insurance in Great Britain. The majority of these have been greatly biased either for or against. I propose to quote largely from an article by Mr. Lester Velie, one of the editors of Collier's, in the issue of March 5 of this year. Mr. Velie visited England and observed the system first-hand. While he tries hard to maintain a detached attitude, it is obvious, both from his writing and from the editorial in the same issue, that he leans toward the side of the proponents of compulsory health insurance. For this reason, I regard his evidence as peculiarily competent for my purpose.

There can be no doubt but that the many people who can obtain spectacles, false teeth, wigs, and other accessories without paying for them are quite approving of the scheme. Of course, someone has to pay for these gifts, but this someone is the British taxpayer. Since many of the beneficiaries pay little or no tax, it is to be expected that they view such a windfall with approval. You would not expect them to criticize Santa Claus. Furthermore, as Mr. Velie points out, some of these beneficiaries are able to barter their medical prescriptions for cosmetics and other toilet preparations, which does not detract from the appeal of this new arrangement.

Let me now quote from Mr. Velie: "To enter London's great Westminister Hospital for a tonsillectomy, a school child must wait, on the average, 15 months. A woman requiring urgent (and I emphasize "urgent") gynecological surgery must wait 7 weeks. So jammed are the free hospitals that many families, even those in modest circumstances, prefer to pay the high cost of child bearing * * * rather than take their chances in state institutions."

It might be argued that this trebled demand for medical service is proof that many people, in urgent need of such service, were unable to obtain it when they had to pay for it. This is not true. The experience in Canada as well as in Great Britain is that this great increase in the demand for medical service is largely in the field of inconsequential ailments which people usually disregard and which take care of themselves. Now that it appears to be a free ride, everyone climbs aboard the gravy train. This is human nature. It is human nature in the United States as well as in Great Britain. As an old doctor acquaintance of mine likes to remark, "Human nature is still prevalent."

So, we see how people in urgent need of medical care for serious conditions fare under such a system. Let's take a look into a British doctor's office through

Mr. Velie's eyes. Within 10 minutes after the doctor's waiting room was opened, there were some 20 patients waiting to see the doctor. "Against one wall," writes Mr. Velie, "was a queue of boys clutching prescription forms in one hand and comic books in another." Mr. Velie inquired about these boys. Here's the doctor's reply: "They are following my system for coping with the health-plan rush. Here, watch this." Thereupon he opened the door to the waiting room, and a boy shot his hand into the doorway, waving a prescription form. The doctor filled out the form. Then another boy shot his arm in, "Father's tablets," he announced. This prescription was written. No patient seen—only prescriptions written. The absurdity, the terrible iniquity of such medical practice seem to have escaped Mr. Velie entirely. No self-respecting physician, with any conscience or the slightest feeling of responsibility for a patient, would stoop to such malpractice were he not driven to it by a stupid government.

After this wholesale writing of prescriptions, sight unseen, asked for by proxy, the doctor began to see the patients who had come in person. Mr. Velie records the consultation in only one such case, and I give it to you as he tells it. The patient was a former prisoner of war who had contracted beri-beri from the deficient prison diet. Apparently, in addition, he was suffering from an acute infection in one of his hands. The hand was badly swollen. Now I shall quote Mr. Velie directly: "He (the doctor) diagnosed the swelling as an infection, prescribed dressings, tonic, rest. 'You'll need several chits, wont you?' (the doctor asked) filling out Government prescription form C–10 for free supplies and another slip for sickness benefits. 'How about my eyes, Doctor?' (asked the patient). * * * The doctor whipped off a green form. He worked unhurriedly, but the patient, forms and all, was disposed of in 7 minutes."

PATIENT "DISPOSED OF" IN 7 MINUTES

This irony seems to have been unconscious on the part of Mr. Velie. "Disposed of" is the only term applicable to a patient who has been given such mockery in the name of medical care. I shall not bore you with a technical dissertation upon the seriousness of infections of the hand. But, to emphasize the inexcusable neglect in this instance, I want to say that infections of the hand are extremely dangerous affairs. Unless treated properly, they aften leave a stiff, useless hand. Upon their hands depends the livelihood of the great majority of workingmen; and good doctors pay more attention to infections of the hand than they do to other conditions which may appear more serious to the layman. So, here is a patient with an infected and badly swollen hand, who is "disposed of" in 7 minutes—which disposition including filling out three Government forms. I am quite familiar with the type of forms used by the British Government. They are just as complex, and as stupid, as the ones used by our own Government. I tell you that no man alive can fill out three Government forms in less than 6 minutes and 50 seconds—so you can see how much personal attention the patient got in the 7 minutes he saw the doctor.

That, my friends, is the practice of medicine under the blessings of compulsory health insurance. But wait—there is some more. Mr. Velie accompanies this same doctor on his round of house visits. He says of the doctor, "In 2 hours he visits more than a dozen patients." This is an average of one patient in less than 10 minutes. Mr. Velie says that the doctor "strides in and out of patients' homes on the double." I think that is a masterpiece of understatement. The only possible way a doctor can make more than 12 house visits in 2 hours is to meet himself going out the door when he is on the way in. This doctor, however, does realize that somewhere there is a limit to the number of patients he can see in a day. He confided to Mr. Velie, "I try not to think what would happen if there were a run of illness later in the winter." So do I try not to think of it—I even try not to think of what is happening to those patients in the slack season.

SYSTEM CREATES CHARLATANS

Now, you may think that this doctor acquaintance of Mr. Velie is an unconscionable quack whose sole motivation is money. It is not true. Mr. Velie describes himself as a thin, unsparingly industrious and forthright man who is held in the highest regard in the town. A system of medicine, like compulsory health insurance has brought everywhere it has been tried, will make a charlaton out of the best of doctors; and there is no term other than charlatanism which describes the quality of medical care which Mr. Velie offers as a typical example. You can have this kind of medical care for yourselves and your families if you want it. As for me, I want no part of it—either on the giving or the receiving end.

One of the most ardent proponents of compulsory health insurance is Michael Davis, the director of the Committee for the Nation's Health—a leftist organization, the principal purpose of which is to secure the passage of this kind of legislation. Davis has been in communication with a friend in London—a gentleman of very wide experience in the field of health care. On February 11, last, this English gentleman wrote Dr. Davis a letter, from which I shall now quote directly: "Now to carry out my promise to give you some information about the working of the new health service. Officially it is said to be working well; unofficially it is known that all is not well." How characteristic of government by politicians. "Officially it is said to be working well; unofficially it is known that all is not well." I continue quoting from this letter: "The first thing that happened when the act came into operation on July 5, 1948, was a rush by the public to obtain the services which the act laid down. But these just did not exist. * * * It was soon evident that a considerable number of people had waited for the 'appointed day' and then demanded the services. Their view was that they were paying for it and they were going to have it." Why not? Can any government justify taking the people's money for a service and then not deliver it? I continue to quote: "There was no increase in the number of (hospital) beds and there was a shortage of medical and nursing staff. The latter (i. e., the shortage of staff) is still giving us a headache. As a result, the staff is overworked and everyone is irritable. This, combined with the changed attitude of the public because they are paying for something which cannot be supplied to them immediately on demand, is definitely having a bad effect on the working of the scheme. * * * One of the greatest objections raised against the service is the waste of time in getting decisions from the central authorities. Whereas, before the act, the committee of each hospital (i. e., the governing board) and the chief executive officers were able to give quick decisions because they were on the spot, under the act they have not the authority to decide upon more than ordinary everyday-to-day routine matters." Does not that sound exactly like our own Federal Government system of control? There is a great similarity among governments.

I continue to quote: "As to cost—the original estimate * * * has gone haywire. Dental service, estimated at £7,000,000 is costing £19,000,000, and would have been higher if the Minister had not drastically cut the fees payable to dentists." Now, there is the totalitarian touch for you. When the service begins to cost too much, the Government drastically cuts the fees it will pay for service. Is this what we are coming to in this country?

But here is the real meat of the matter to me. I continue to quote: "One thing that is very noticeable is the loss of the human or personal touch. There is an official air about everything, and every officer is standing on his position and authority. * * * I am much afraid the hospitals are going to consider administrative efficiency and keeping within the rules as being of far greater importance than personal attention to the patient."

There you have it—loss of the human touch—assembly line technique in medical care—more attention to regulations than to care of the patient. You say that can never happen here. Well, it has happened here. Those identical words describe exactly the situation in our own veterans' hospitals before General Bradley changed it. How familiar those words are to me.

Now, you may think the writer of this letter has always been opposed to compulsory health insurance, and consequently can see no good in it because of his prejudice. So I shall quote once more from his letter: "Basically, the principle * * * of a comprehensive health service for the Nation is as sound as ever, but the practical application of the principle leaves much to be desired." Here is the picture of the disillusioned zealot—the idea is good, but it just won't work.

THE DEATH RATE

I stated some minutes ago that the objective of any health program should be the reduction in disability and the lengthening of life, but that the proponents of compulsory health insurance appear to be making compulsory health insurance itself the objective. Throughout The Nation's Health is reiterated the theme that the principal reason that our death rates are not lower than they are is that the economic level of so much of our population is too low to permit the purchase of good medical care. I now quote from The Nation's Health: "The quality and amount of care given to the needy, and available to all, depend upon the income level of the community in which they live (p. 7). * * * If we had enough medical manpower and hospitals everywhere, and a better system of financing medical care * * * our present total of 1,400,000 deaths could be sharply reduced (p. 8) * * * If we continue in the present pattern, it is true that there will be gradual improvement in some parts of the country but in general the gains will come in those areas which already have a relatively high level of health service," (p. 12).

Now, as Al Smith was wont to say, "Let's look at the record." The three States with the highest per capita income are Nevada, New York, and California. The three States with the lowest per capita income are Mississippi, Arkansas, and South Carolina. Nevada and Arkansas were admitted to the registration area of the United States too recently to be of use in this study. So, I shall consider the States with the second and third highest per capita income—New York and California—and the States with the lowest and third lowest per capita income—Mississippi and South Carolina.

In the 27 years between 1920 and 1946, inclusive (the latest published experience), the death rate in New York and California declined 23 percent. During those same 27 years, the death rate in Mississippi and South Carolina declined 32 percent. In other words, the death rate declined almost 50 percent faster in the low-income States than it did in the two high-income States. Furthermore, the two low-income States have a very high proportion of Negroes in their populations. Negroes have an appreciably higher death rate than white. But, despite this handicap, almost 50 percent more lives have been saved, in proportion to population, in the low-income States than were saved in the high-income States. Furthermore, in 1946 the death rate in the two low-income States was 15 percent lower than it was in the two high-income States.

It simply is not true that thousands of people die every year in this country because of inability, financial or otherwise, to obtain medical care. It is true, perhaps, that thousands die because of personal negligence or procrastination in seeking proper medical care. It may well be true that some die because of a want of skill on the part of the physician which they chose. But there is not the slightest evidence that there is any significant number of people dying today because it is impossible for them to obtain medical care.

Those who contend the opposite confuse medical attention with medical care. I am fully aware that there are millions of people who cannot afford to run to a doctor's office every time they need a cathartic, or to call a pediatrician to their home every time the baby sneezes. As a matter of fact, the world would be much better off if no one had money to waste in this way—if the rich were denied medical attention except at the time they needed medical care.

CLAIMS NOT AUTHENTICATED

This propoganda that millions of our people are suffering and thousands dying because of inability to obtain necessary medical care reminds me of the Belgian atrocity stories of World War I. You will remember the propaganda broadcast throughout Allied countries that thousands of Belgian children had been mutilated by the occupying Germans. When these stories were investigated after the war, every Belgian villager was sure that they were true—he had it upon the most reliable evidence—but they had always happened in another village, never in his own village. And now we are being propagandized in exactly the same way by Government officials at the expense of the taxpayer. I should like to have authenticated records of only a few hundreds of these cases—not thousands. But, like the tortured Belgian children, they seem always to have occurred in the next town.

One element of the compulsory health insurance program of the Federal Security Administration that is being a carefully kept secret is its cost. By two independent methods of approach to the problem, careful investigators have estimated the cost to be $100 per capita per annum, when the program is in full operation. This is $15,000,000,000 a year. The pay-roll deductions and employer contributions fixed by the Federal Security Administration will produce $6,000,000,000 per year. Thus the contributions to the fund will pay no more than 40 percent of the cost. Here I would point out again that this huge cost is not for necessary medical care but largely to satisfy the capricious desire for medical attention for inconsequential ailments. In the present state of our national budget, can any intelligent citizen advocate adding $9,000,000,000 per year for the sole purpose of gratifying the demands of neurotics, malingerers, and chiselers?

However, do not let the evidence of bad faith on the part of the proponents of compulsory health insurance obscures the fact that there is a pressing need in this country for a mechanism that will ease the burden of necessary and expensive medical care. The cost of medical care has risen steeply in the past 10 years—and for two reasons. First, there is the general rise in costs—or decline in value of the dollar, as you prefer—with which you are all familiar. In addition, medical care has become infinitely more complex and thereby very much better. Just as the airplane costs more than the stage coach, so medical care of today costs more than what passed for medical care only a few years ago. Diagnosis is no longer a matter of a glance at the tongue and a thump on the chest. It is often a complex technique requiring a number of people in laboratories in addition to the physician at the bedside. Diagnosis is much more accurate and treatment much more effective—both of which are reflected in our rapidly increasing length of life—and the improvements are well worth the higher cost. Just as increased cost of air travel will not drive us back to the stage coach, so increased cost of medical care will never drive us back to primitive medical practice. We must find another solution to this problem.

In fact, we have found another solution to the problem. The necessity for medical care is a risk which is unpredictable in the individual case but predictable with surprising accuracy in the mass—just as the risk from loss by fire, by marine disaster, or by tornado. In other words, the need for medical care is an insurable risk.

Medical care insurance has been working with reasonable success for some 20 years. I do not say that it is perfect, but I can and do say that it is improving all the time. and that the day is not far off when it will meet every real need of our people.

The question of the necessity for medical care insurance is no longer an issue. The principle of medical care insurance has been enthusiastically accepted by the great majority of our people. Already, some 60,000,000 Americans are protected to some degree by some kind of medical care insurance. The only question yet at issue is whether medical care insurance shall continue as a voluntary effort in a free-enterprise system or whether it shall be replaced by compulsory health insurance in a socialistic state. Let no one dodge the crux of this issue—once we have compulsory health insurance, we have a socialistic state. Of course, for a time there will continue to exist remnants of a free-enterprise system; but once the state becomes socialistic, as it does when it accepts the principle of compulsory health insurance, these remnants of free enterprise will be subjected to a mopping-up operation just as is now going on in England. England has gone socialistic—period. What still remains of free enterprise there is rapidly being absorbed into the general pattern of socialism.

NO RETRACING OF STEPS

Experiments in socialism would teach us by that best of schools—experience. They would be very much worth while for us to try, except for one thing. That is that such experiments are impossible because they cease to be experiments the moment they are launched. There is no retracing of steps taken along the road to socialism. No nation has turned from socialism save through bloody revolution—whether the blood has been spilled in the battlefield as in Spain—or in tourture chamber as in Nazi Germany. All such revolutions have been extreme, like the swing to phalangism in Spain, fascism in Italy, and nazism in Germany. I believe fully that, if the United States does become socialistic—which God forbid—our people will not long remain tolerant of such government. But I shudder to contemplate the form their reaction must take when they decide to throw off the shackles upon their freedom. We are not a complacent people. We can be deceived and cajoled into acceptance of false gods, but a day of reckoning will surely come.

Time does not permit me to present the complete case against compulsory health insurance. I have had to confine myself to a few of its iniquities. Were I not so concerned over the disastrous consequences of compusory health insurance, I could find amusement in watching the frantic efforts of some of our Members of Congress to place this keystone in what Lenin called the arch of the Socialist state while parading before their constituents in the borrowed and ill-fitting raiment of statesmen in the American tradition. I think it is just as dishonest and just as reprehensible to attempt to buy votes with promises of Government hand-outs as it is to buy them openly with hard cash; but this seems to have become the political fashion some 16 years ago—the new look in politics as well as the New Deal. If it continues, the Lord only knows where we shall end up.

NONPROFIT HEALTH SERVICE PLANS

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I. Introduction

The continual improvements in medical techniques and equipment in the United States have been of tremendous benefit to the health of the Nation; they have also made medical care increasingly expensive. The average American is much more "health conscious" today than was his father. He hears and reads about new developments in the medical sciences and when he or his family falls ill, he tends to seek the best care available. Since illness and accidents are unpredictable for the individual, the responsible American wants some protection against the financial hazards involved.

The obvious answer lies in some form of insurance, or prepayment. Although a relative newcomer to the insurance field, "health service insurance" has now been established long enough to have accumulated adequate actuarial data upon which to base a financially sound operation. The phenomenal growth of such insurance, particularly of the nonprofit Blue Cross (hospital) and Blue Shield (medical) plans, has enabled many millions of people to prepay their medical expenses on a personal budgetary basis.

An important byproduct of these prepayment systems has been the rise of many patients from a charity status to a medically self-supporting status. The typical American of modest income hates to be a recipient of either private charity or Government charity. By participating voluntarily in a prepayment plan, he is able to maintain his self-respect without catastrophic effects upon his bank account. At the same time he is free from the paternalism and the bureaucratic arrogance, inefficiency, and interference which would result from a federally administered, tax-supported, compulsory system such as has been proposed by a vociferous minority in this Nation.

The voluntary plans now in operation have proved themselves. They have steadily broadened the scope of their benefits and have developed administrative techniques to hold operating cost down to a minimum. They have made great contributions to the development of the entire field of prepayment of medical and hospital care through cautious experimentation in hitherto unexplored areas. If allowed to expand without interference from Government, they can eventually cover the major costs of illness for all but a marginal segment of the population. It is the purpose of this chapter to trace briefly the historical development of the prepayment plans, to describe their methods of operation, to discuss some unsolved problems, and to look into the future.

II. Significance of Blue Cross and Blue Shield

It is customary to separate voluntary, that is nongovernmental, hospital, and medical service prepayment or insurance into two main categories; namely, commercial and nonprofit. Since, however, mutual insurance companies are in a sense nonprofit organizations, perhaps a clearer understanding of the two main types is to be gained by defining them thus: (1) Insurance in terms of cash indemnity collected from the insurance company by the policyholder after the latter has paid his bill to the hospital or doctor in person; (2) Blue Cross and Blue Shield prepayment plans, under which the benefits are rendered primarily in the form of hospital or medical service to the subscriber and the insuring organization pays the subscriber's bill direct to the hospital or physician. A second, and equally major feature of the latter arrangement is that the hospitals and doctors themselves assume responsibility for the benefits as defined in the particular contract, and guarantee that they will furnish them, within certain time limits, even though the plan itself may at any time be financially unable to pay the hospitals or doctors the charges agreed upon.

With few exceptions, stock and mutual insurance companies operate on the former basis. Likewise, with a few exceptions, "plans" operating on the latter basis are those which are nonprofit and are officially approved by the American Hospital Association or by Associated Medical Care Plans, Inc. Such approval carries with it designation of the plan by the emblem of the American Hospital Association superimposed upon a blue cross, or by the AMCP's blue shield emblem.

Some of the old-line life and casualty insurance companies have offered hospital and medical insurance for a number of years. No very widespread demand, however, was built up until the Blue Cross (and later, the Blue Shield) plans began to achieve national popularity by virtue of the service-benefit feature and of the low operating cost ratio resulting from nonprofit operation. As the American public has become more and more health-insurance conscious, the commercial companies have themselves benefited by this publicity and are now selling their own policies more extensively than ever before.

The Blue Cross plans, however, remain far and away the most popular method of hospital service prepayment, with an enrollment of more than 33,000,000 persons as this goes to press. Various estimates have been made of the total number of people covered by commercial indemnity hospitalization insurance. The United States Public Health Service estimated that some 12,500,000 persons had a substantial degree of such coverage on January 1, 1947.

A number of large industrial firms, labor unions, and other organizations are coming more and more to contract for a "package plan" including life insurance, disability, medical indemnity, and hospitalization, often combining Blue Cross for the last-named coverage with commercial for the others.

Since Blue Cross plans are sponsored by the Nation's community hospitals which in turn are supported by the general public, and since these plans are administered by governing boards representing the public as well as the hospital and medical professions, they should be regarded as a form of social insurance—as a substitute for Government-controlled insurance—rather than as competitors of stock and mutual insurance companies.

Legally, the position of Blue Cross plans is determined by the charters under which they are incorporated in the various States and by the statutes under which they operate. Blue Cross plans operate in 47 of the 48 States (the exception is Nevada), and in every one of these States the Blue Cross plans are exempt from corporation income taxes. The commercial companies, which are subject to such taxation, frequently express the opinion that this is unfair discrimination. To date, however, the tax-exempt status of the Blue Cross plans has been upheld in every State in which it has been challenged.

III. OTHER HEALTH INSURANCE

COMMERCIAL INSURANCE

Besides the 12,500,000 persons estimated to hold commercial accident and health coverage for hospitalization expense, some 9,300,000 have commercial protection for surgical and obstetrical service. Coverage of other medical services is still largely in the experimental stage and is held by not more than 850,000 persons.

About three-fourths of these people are insured on a group basis. The large life-insurance companies have offered such coverage for a number of years. The contract is between the insurance company and the employer. This insurance ordinarily is offered to the employee regardless of his income and without physical examination. A minimum percentage of the employees in any given firm is required to enroll (usually 75 percent). In the early days, such coverage was offered only to firms with more than 100 employees. This minimum has been reduced from time to time and at present it is usually 25 employees.

At first, this coverage was sold only to male risks. More recently, however, it has been extended to women. However, the premium rate typically increases in direct ratio to the percentage of female employees in any given organization. Occasionally it may be extended to the family dependents of employed people; but, for the most part, it is confined to the employees themselves.

The extension of commercial group hospitalization insurance has taken place mostly since 1935, coinciding with the growth in national popularity of Blue Cross nonprofit hospital service plans.

Commercial insurance for surgical expense in group form also existed in negligible amounts in 1935, but has since grown to very considerable proportions. In 1938, insurance companies began to offer this coverage in connection with group hospital insurance. The beneficiary was reimbursed for surgical fees according to a schedule of fees for various kinds of operations.

Coverage for physicians' visits in the hospital, office, or home is very recent. No very great number of persons had been covered prior to the year 1945.

Individual or nongroup policies have been offered by a number of commercial companies. But, on the whole, this is not a very thriving or substantial business. The percentage of the premium dollar which goes back to the policyholder in benefits is often quite small. The 1946 report of the National Underwriter Co. showed that benefits ranged all the way from 20 cents to 70 cents on the premium dollar, with the average less than 50 cents.

INDUSTRIAL PLANS

Some industrial concerns and other firms have set·up their own medical-care plans covering their employees and sometimes the employee's family. Usually services are provided by hired staff physicians. Some firms operate their own hospitals. Usually, the cost, or a major part of it, is borne by the employees through pay-roll deduction. A survey in 1945 reported on 115 such plans covering 1,435,000 persons for hospitalization and a somewhat lower number for other types of service. There has not been any very appreciable increase in coverage of this sort in recent years.

EMPLOYEES' MUTUAL BENEFIT ASSOCIATIONS

Sickness benefits were provided by employee mutual benefit associations for several decades prior to the enactment of the first workmen's compensation law in 1910. The precedent of employer responsibility for industrial accidents to workers had not yet been established. So the workers formed their own associations, contributing periodic dues from their wages to a mutual fund to cover the expenses of disabling accident or sickness. This form of sickness insurance became increasingly popular until about the middle 1920's, or about the time when group insurance began to attain a considerable degree of efficiency. Although some employee associations furnish medical care, most of them concentrate to the payment of weekly cash benefits during periods of disability. It has been estimated that there are about 600 mutual benefit associations in the United States covering about 1,500,000 employees.

TRADE UNION PLANS

Trade union benefit plans also come into being prior to the enactment of workmen's compensation legislation. Like the employees' mutual benefit associations, the trade union plans are designed to protect the worker against the loss of wages, rather than against medical expenses. Where sick benefits have been provided to any substantial degree the unions have usually turned to outside organizations for the provision of such protection. It has been said that the administration of sickness benefits conflicts with the fundamental purposes of a trade union, by diverting funds away from enterprises for which the union primarily exists. It is readily evident how disagreement can arise over such a question as whether union funds should be used for strike benefits or as a reserve in the event of a strike, or whether they should be allocated to the sick benefit fund.

OTHER PLANS

Several other forms of sickness insurance may be mentioned briefly:

The former Farm Security Administration (now the Farmers Home Administration) set up hospital and medical service benefits for low income farm families to whom it loaned money. In 1942 more than 500,000 persons were covered. But this program is on the wane and as of June 30, 1946, only 134,000 were covered for hospitalization and 165,000 for physicians' service.

Private group clinics have been set up in a number of communities by groups of physicians providing services on a prepayment basis. Outstanding among such groups is the Ross-Loos medical group in Los Angeles. Groups of this sort cover altogether some 400,000 persons for surgical and medical services in the hospital.

Many colleges and universities provide medical services to students on an annual fee basis. It is estimated that at least 100,000 students are thus covered.

A number of hospitals have individual prepayment plans of their own. There are also some nonprofit hospital service plans involving more than one hospital which are not approved Blue Cross plans. Lack of Blue Cross approval may be due either to failure of such a plan to make application for approval or failure to meet the American Hospital Association standards where such application has been made.

Consumer cooperative groups have set up prepayment plans in many areas. In fact, this type of plan dates back as far as 1851, when the French Mutual Benevolent Society was organized in San Francisco, Calif. Wide expansion, however, did not come until the 1930's. In 1946 a conference of cooperative and consumer-sponsored health service plans was held and a national organization was set up—the Cooperative Health Federation of America. The American Medical Association has record of 79 consumer-sponsored plans in 27 States. They are supported by labor unions, by workers in a particular industry and by farm organizations. The enrollment of 48 of these plans total 674,653, of which 245,770 is rural. Projecting the average enrollment to the remaining 31 plans, the total enrollment of 79 may be estimated at 1,106,000.

In general, the business affairs of these associations are managed by nonprofessional boards of directors. Many of them have a medical board or a physicians' committee to direct the medical practice. Some have contracts with physicians responsible to the board to handle the medical practice.

As for facilities, some of these plans have their own hospitals or clinics, while others use existing local facilities. Usually, the contracts is for service benefits rather than indemnity, and the trend is in the direction of more or less complete service benefits.

IV. Early Development

PREPAYMENT IN THE XVII CENTURY

So far as available sources reveal, the earliest health service prepayment plan on the North American continent was one formulated in the year 1655 at Ville-Marie on the island of Montreal. According to a document dated March 3 of that year:

"Urbain Tessier dit Lavigne (and) 36 others, acting both for themselves and their families and children, (contracted with) Etienne Bouchard, master surgeon of the said Ville-Marie * * * (for the latter) to dress and to physic, of all sorts of illness, whether natural or accidental, except the plague of smallpox, leprosy, epilepsy, and lithotomy or cutting for the stone * * * in consideration of the sum of 100 sous each year, payable by each of the above-mentioned persons * * * in two terms and quarters * * * and to treat also their children who may hereafter be born. * * *"

The contract was cancellable by either party "upon giving due notice to those concerned, such notice to avail only for the years which have not yet begun to run. * * *"

On August 20, 1681, likewise at Montreal, Rev. Mother Renee Le Juneau, superior of the Dames Religieuses Hospitalieres, contracted with Sieur Jean Martinent de Fonblanche and Antoine Forestier, master surgeons, for medical and surgical services to patients in their hospital, "in consideration of the sum of 75 livres each for each year * * * and upon condition that the said surgeons cannot claim or seek to recover anything else whatever from the said patients."

INITIAL VENTURES IN THE UNITED STATES

As long ago as 1880, hospital service insurance plans were in operation in northern Minnesota. These were developed for the benefit of the lumberjacks. In various other parts of the country, particularly in regions remote from civilization such as mining camps and lumber camps, hospital and medical service plans were developed by companies engaged in those fields.

In 1912 a plan was organized in Rockford, Ill., under the name of the Rockford Association. It was set up as a nonprofit Illinois corporation, with membership open to any resident of the community over 15 years of age and free from chronic illness. Benefits included 6 weeks' hospital room and board, and operating room fee.

In 1921 a hospital in Grinnel, Iowa, developed a plan covering cost of room and board and nursing up to a period of 3 weeks. Special services were not included.

The Thompson Benefit Association for hospital service was organized in Brattleboro, Vt., in 1927. It covered hospitalization expense up to a maximum of $300 including surgeon's fees.

The plan, however, which is generally considered to be the nearest prototype of the present day Blue Cross plans was one organized in 1929 by the school teachers of Dallas, Tex. Approximately 1,500 teachers were insured for hospital care at the rate of $6 per person per year. Hospital services in semiprivate rooms included not only room, board, and nursing but also operating-room service, anaesthetics, laboratory fees, routine medicine, surgical dressings, and hypodermics. Full coverage was provided for a period of up to 3 weeks with a 33-percent discount for longer periods. The plan was worked out by agreement with the Baylor University Hospital through the cooperation of Dr. Justin Ford Kimball, vice president of the university. Not long afterward the enrollment was thrown open to people other than school teachers. Successful operation continued to the satisfaction both of the subscribers and of the hospital.

The first multihospital plan was organized in Sacramento, Calif., in 1932. In certain other communities, more than one local hospital had set up its own plan, with the result that there was competition among the hospitals and interference with the subscriber's free choice and with the physician's prerogatives in the care of private patients. In Sacramento, the hospitals joined together to offer service contracts to the employed people of the city. The hospitals themselves supplied the initial working capital. The organization was in the form of a mutual insurance company.

In January 1933 a plan was set up on a county-wide basis in Essex County, N. J., through the Hospital Council of Essex County. The council authorized a private promotion agency to contract with employed people for hospital service. After a 6-month period the initial working capital provided by the agency was returned, its services were discontinued, and the hospital council itself took over the management of the plan. In 1937 the plan was extended to the whole State of New Jersey and it is now the Blue Cross plan of that State.

In 1933 five other nonprofit community group hospitalization plans were initiated, in St. Paul, Minn., Durham, N. C., San Jose, Calif., and West Virginia, two plans having been started in the last State.

The year 1934 saw the beginning of three more nonprofit plans. The Hospital Service Association of New Orleans took over certain contracts of Touro Infirmary which had had an experimental plan since 1932. A plan was started in Washington, D. C., with an initial capital supplied by the community chest. The Cleveland Hospital Service Association was organized by the Cleveland Hospital Council and working capital was loaned by the Cleveland Welfare Federation.

By the end of 1935, nonprofit community hospital service plans had begun to multiply so rapidly as to take on the nature of a national movement. In that year, the Associated Hospital Service of New York (New York City) was organized under a special enabling act. Two other plans were started in New York State, one in Delaware, one in North Carolina, one in Pennsylvania, one in Tennessee, and two in Virginia.

The passage of special enabling legislation in New York State was a noteworthy landmark in the development of the movement. The State superintendent of insurance had ruled that the proposed hospital service plans would be engaging in insurance. Previously, in the other States where such plans had been set up, their sponsors had assumed that they did not constitute insurance but rather the sale of hospital service on a prepayment basis. When the attorneys general or insurance departments of those States had been asked for a ruling they had ruled to that effect, and had ruled that the plans could incorporate under the general incorporation laws and that they were exempt from the regulations covering stock and mutual insurance companies. This exemption was important in that it meant that subscribers did not have to be liable for assessments and that the plans could start without the large capital required of stock companies.

When the New York superintendent of insurance ruled that the proposed New York City plan would be insurance, local civic leaders, hospital officials, and physicians drafted and sponsored a bill for a special enabling act. It was passed and became law on May 16, 1934.

The act stated that any corporation organized for the purpose of operating a nonprofit hospital service plan should be governed by the provisions of this act, and should be exempt from all other provisions of the insurance law; that at least a majority of the directors of such corporations must be administrators or trustees of hospitals which have contracted to render service; that such organizations shall be incorporated only with the consent of the insurance and welfare departments; that the rates charged subscribers shall be subject to the review of the insurance department and the rates of payment to hospitals subject to the approval of the welfare department; that such organizations shall render reports to and be subject to examination by the superintendent of insurance; and that every such corporation is declared to be a charitable and benevolent institution and exempt from State or local taxes other than taxes on real estate and office equipment. From this time on, in virtually all of the remaining States, the passage of somewhat similar legislation was a prerequisite for the starting of plans. Enabling legislation has been passed in 35 States.

V. The Blue Cross Movement

ROLE OF THE AMERICAN HOSPITAL ASSOCIATION

Sensing the growing significance of the nonprofit hospital service prepayment movement, the board of trustees of the American Hospital Association decided in 1933 to make a special study of it with view to recommending standards to guide its development. A resolution was adopted to the effect that the American Hospital Association approved the insurance principle as a practical solution of the problem of distributing the cost of hospital care as borne by persons of limited income. The Council on Community Relations and Administrative Practice was instructed to study the problem and make recommendations.

The council report listed "Essentials of an acceptable plan for group hospitalization" as follows:

1. Emphasis on public welfare.
2. Limitation to hospital charges.
3. Enlistment of professional and public interests.
4. Free choice of physician and hospital.
5. Nonprofit organization.
6. Economic soundness.
7. Cooperative and dignified promotion.

Endorsement of generally similar standards was voted by the American College of Surgeons in 1934, by the Catholic Hospital Association in 1937, and by the American Medical Association in 1937.

The American Hospital Association continued to study the development of the prepayment plans and to accumulate statistical data concerning them. In January 1937 it established the Committee on Hospital Service (the name was later changed to Commission on Hospital Service, to Hospital Service Plan Commission, and finally in 1946 to Blue Cross Commission). Under one name or another the commission has functioned continuously since its founding as a coordinating agency for the nonprofit hospital service prepayment plans which conform to the American Hospital Association standards. A full-time director and staff have been maintained at the association's headquarters.

The commission's first act was to call a national meeting of the executives of nonprofit hospital service plans on February 15, 1937, in Chicago. Similar meetings have been held every year since that time. At the first meeting it was announced that the American Hospital Association had authorized associate institutional membership in the association for nonprofit plans. A set of formal approval standards, based on the 1933 "essentials," was drawn up by the commission and on April 1, 1938, the American Hospital Association formally approved 40 plans on the basis of these standards. First approval and annual reapproval of the plans are the responsibility of the American Hospital Association's board of trustees upon recommendation by the commission. Standards for initial approval, as revised in 1946, are as follows:

(1) Adequate representation of hospitals, the medical profession, and the general public on the governing board.

(2) *Nonprofit sponsorship and control.*—Board members receive no remuneration for their services in that capacity. Initial working capital should be repayable out of earned income, and no organizations or individuals advancing capital should attempt to influence management of the plans because of their financial support.

(3) *Free choice of hospital and physician.*—All institutions of standing in the prescribed area should be given an opportunity to become member hospitals in the plan, and the subscribers should have free choice of hospital at time of sickness.

(4) *Responsibility for benefits to subscribers.*—The ultimate responsibility must be assumed by the member hospitals through contractual arrangements with the plan. In the absence of such provision the plan must establish contingency reserves equal to 25 percent of the plan's annual income.

(5) *Enrollment areas and practices.*—Plans should be established only where the needs of a State or Province are not already adequately served by existing Blue Cross plans. Adequate spread of risk and economical management require that each plan serve the largest possible area permitted by legal and economic conditions. Enrollment practices should be designed to assure a utilization approximating that of the general population.

(6) *Sound accounting practices.*—The commission shall enforce minimum standards of sound accounting practices and shall require each approved plan to submit periodic reports of financial experience.

(7) *Adequate general or contingency reserves.*—Initial working capital should be sufficient to carry all operating expenses for at least 4 months after contracts first become effective. The plan is expected to establish a reserve for contingency to cover items such as major epidemics, etc.

(8) *Adequate statistical records.*—The plan is expected to report such statistical material as may be requested by the commission.

(9) *Equitable payments to hospitals.*—In determining any method of payment for contract benefits, plans and their member hospitals should exchange adequate financial and other data concerning one another's operation. The plan and its member hospitals are expected to review periodically any method of payment by the plan for contract benefits, with view to making such adjustment as may be necessary to protect the interests of plans, hospitals, and subscribers.

(10) *Dignified promotion and administration.*—Plan employees should be reimbursed by salary as opposed to a commission basis. A private sales organization must not be given the responsibility for promotion or administration on the basis of a percentage of premiums. Promotion should be conducted in a dignified manner consistent with the professional ideals of the hospitals concerned.

(11) *Interplan coordination.*—Plans are expected to coordinate their activities, particularly in the following ways: (*a*) Permitting transfer of subscribers who change their permanent residence; (*b*) reciprocal service benefits for subscribers hospitalized in the areas of other plans; (*c*) uniform enrollment and billing procedures for employees of national firms enrolled through two or more plans; (*d*) consolidated billing for employees of national firms which request such procedure.

Any nonprofit hospital service plan wishing to apply for Blue Cross approval may obtain from the Blue Cross Commission an application form calling for information which will indicate whether or not the plan meets the approval standards. After studying such application the Blue Cross Commission makes recommendations to the board of trustees of the American Hospital Association. Final decision as to approval rests with the board of trustees.

Approval is on a year-to-year basis. In order to obtain reapproval each year the plans must submit applications for reapproval and furnish evidence that they are complying with the approval standards. Certificates of approval are issued annually over the signatures of the officials of the American Hospital Association and of the Blue Cross Commission.

ACTIVITIES OF THE BLUE CROSS COMMISSION

In addition to its functions in connection with the approval program, the commission exists for the following purposes, as defined in its administrative regulations:

(1) Secure the widest possible public acceptance of the principle of voluntary, nonprofit, prepayment health service.

(2) Secure the acceptance by members of programs of joint action.

(3) Administer such national programs in furtherance of these purposes as are agreed to by the conference of members.

(4) Provide members with such research, consultative, and informative services as may seem desirable or necessary.

A BLUE CROSS PLAN DEFINED

A Blue Cross plan is a nonprofit corporation organized under community and professional sponsorship and approved by the American Hospital Association for the purpose of enabling the public to defray the cost of hospital care on a prepayment, group, basis. Benefits are in terms of hospital service rather than cash indemnity and are guaranteed by the participating hospitals through contractual arrangement between the hospitals and the plan. There is an agreement between the subscriber and the plan, listing benefits to which the subscriber is entitled. When a subscriber has occasion to be hospitalized, he may choose any member hospital of his plan, subject to his attending physician's referral. (The determination of the necessity for hospitalization remains with the physician.) Upon admittance to the hospital he presents his Blue Cross identification card and no further credit reference is ordinarily required by the hospital. Upon discharge he is billed by the hospital for only such special services as may not be included in his Blue Cross contract, his eligibility for care having been confirmed by the plan during his stay.

Out of its subscription income the plan pays its hospitals for the services rendered to its subscribers. These payments are made on a basis previously determined by mutual agreement and approved by the proper regulatory bodies of the State in which the plan operates.

In addition to the service contract benefits available to subscribers in member hospitals of each plan, the plans also make provisions for cases where the subscriber has to be hospitalized elsewhere, as while traveling or while in temporary residence in another area. In such cases the plan frequently reimburses the subscriber a fixed cash amount per day of hospitalization. Many plans, however, are participating in a reciprocal program (which will be described later), enabling them to provide service benefits "out of area." Thus the subscribers of any one Blue Cross plan are protected to a substantial degree regardless of where they may be at the time of hospitalization. This coverage extends to any accredited hospital in the world.

ORGANIZATION OF BLUE CROSS PLANS

Blue Cross plans are sponsored locally by the hospitals, the medical profession, and the general public. In most cases the principal initiative in the formation of a plan has been the county or State hospital association, which is only natural. However, it is evident that no plan can succeed without the approval and support of the medical profession and of the public at large. Initial working capital has often been provided not only by the hospitals but also by local community chests, business and civic organizations, foundations, and individual civic leaders. Initial capital is usually repaid within a very short time out of plan income.

CONTROL OF THE PLANS

Blue Cross plans are controlled by their boards of directors (sometimes called trustees). The board appoints the executive director and decides all major policies. The method of election or appointment of board members varies in different localities. In fact, there is so much variation in this respect that generalizations are difficult to make. A few remarks, however, may be pertinent. In a majority of the plans the entire board is elected by the members of the corporation. In such plans the extent to which the member hospitals influence the election of board members depends upon the representation of the hospitals in the corporation. This varies considerably but in many cases each member hospital has a representative in the corporation. In other instances, the local hospital association elects a certain number of representatives from the hospital field to the board.

In a smaller number of plans, each member hospital has the right to appoint its own representative on the board.

In one plan the entire board is appointed by the member hospitals.

Regarding the extent to which the medical profession controls the election or appointment of board members, in about one-half of the plans there is no official control of appointments by the profession. In about one-third of the plans the local medical society has definite authority to appoint a certain number of board members. In about a dozen plans the medical society does not have specific powers of appointment but the doctors are represented by voting members in the corporation. In no plan is the entire board appointed by the doctors.

The above paragraphs, however, are by no means to be taken as an indication of the proportional representation of hospitals and doctors on the plan boards as they actually exist. The medical profession is represented on virtually every board to some extent and in the case of about half of the plans to the extent of 20 percent or more of the board membership. Hospital representatives are in the majority in about two-thirds of the plans.

Representatives of the general public are present to the extent of 20 percent or more on the boards of the great majority of the plans. This means people not directly or officially connected with hospitals or the medical profession.

However, the proportion of "public" representation may actually be considerably greater than the above would indicate, because many boards include hospital trustees who are civic leaders in other fields as well, and may very well consider themselves representatives of the community rather than of the particular hospital with which they are associated, or of hospitals in general. Board members who are hospital administrators, on the other hand, may naturally be expected to have the interests of the hospital primarily at heart.

Direct representation of the subscribers themselves, as such, is a recent development. It may take any one of several forms, such as the following:

In the Massachusetts plan, not to exceed 46 subscriber groups have one vote each as voting members of the corporation which elects the board. In the New York City plan, several of the voting members of the corporation must be directors of the United Hospital Fund, which means that they are prominent civic leaders. A certain number of the board members must be chosen as representing large subscriber groups. In the Philadelphia plan, the subscribers are entitled to elect six of the board members.

In the Washington, D. C., plan, one-third of the board members are appointed by the Commissioners of the District of Columbia.

In the Cincinnati plan, subscriber councils are elected, consisting of representatives of each subscriber group. Councils elect regional subscriber committees which in turn elect a subscriber committee for the plan as a whole. The chairman of the last-named committee is automatically a member of the plan board.

In Kansas an arrangement prevails similar to that of Cincinnati, with the chairman of the State subscribers' council becoming automatically a member of the plan's board of directors.

Regarding control of the plans in general, hospital representatives appear to play a dominant role in most cases as far as official representation in concerned. However, it may not be too much to say that when civic-minded hospital trustees (that is, trustees who will vote on matters of plan policy in terms of their conception of the public interest rather than of the interests of their hospitals) are added to those board members who are officially representatives of the public, control of the plans in most cases is dominated by the people who think of themselves as acting in the public interest rather than in the special interests of the hospitals or of any other special group.

ENROLLMENT METHODS AND SERVICE

Blue Cross enrollment has been primarily conducted among groups of people working for a common employer. The group insurance principle, with insistence upon a minimum percentage of enrollment within each group, minimizes adverse selection of risk and makes possible maximum extension of benefits. It also helps to put the plan into an actuarial position whereby it can carry nongroup subscribers and other poorer risks, thus carrying out the social purpose of Blue Cross plans in extending coverage eventually to the largest possible cross section of the entire population.

The minimum percentage of enrollment required within each group varies in inverse ratio to the size of the group.

Besides groups united by a common employer, groups suitable for enrollment may be those with some other common economic interest, such as the membership of a trade-union, a professional society, or a trade association.

The minimum size of an eligible group varies among the plans but the tendency is to extend eligibility to smaller and smaller groups—sometimes as few as two or three persons. In general, 100-percent enrollment is required in groups of 10 or less, with the percentage decreasing to about 40 or 50 percent in groups of 25 or more.

Ordinarily contact is first made with the employer to secure his sponsorship and if possible his cooperation in the collection of subscription charges—preferably by pay-roll deduction, which, of course, minimizes clerical expense of the plan. Enrollment opportunity is then presented to the employees through literature and through personal presentation by plan representatives, and a dead line for initial enrollment is set. After the initial enrollment, arrangements are made for enrollment of new employees, and old employees who did not join at the time of the initial enrollment are usually given an opportunity to join at stated intervals, ordinarily semiannually or annually.

PAYMENT OF SUBSCRIPTION DUES

Pay-roll deduction is the preferred method for collecting subscription dues. The employer assumes the task of collection by deducting the subscription from the employees' pay checks and remitting the total amount monthly to the plan.

When deduction is not obtainable, or in groups that are of such nature that they do not have a common employer, a group leader or group treasurer is chosen by the subscribers and voluntarily assumes responsibility for collecting from each individual and submitting the total to the plan at stated intervals. The group leader receives no compensation other than reimbursement for postage, stationery, etc.

When a subscriber leaves an employed group he is permitted to continue his membership on a direct-payment basis, usually at a slight extra charge. The term "conversion' 'is used to indicate the change from group membership to direct-pay membership, or vice versa. Persons originally enrolled in a community enrollment (see below) usually pay their dues direct to the plan. Original enrollment is also sometimes offered on a direct-pay basis. With pay-roll deduction, payment is usually made monthly. Quarterly remittance is the most common method used for those paying direct. Sometimes payment is made on a semiannual or even on an annual basis, as in the case of community enrollments—particularly in rural areas.

DEVELOPMENTS IN NONGROUP ENROLLMENT

Community enrollment

In order to fulfill one of the social purposes of Blue Cross and reach the widest possible segment of the population, rather than enrolling only preferred risks, most plans offer enrollment to persons who are not members of employed groups. A Blue Cross Commission survey completed in June 1947 revealed that approximately 20 percent of the entire membership of Blue Cross plans was enrolled on a nongroup basis. The most effective method of doing this which has so far been devised is to throw open enrollment at periodic intervals to all persons in a community who are self-employed or unemployed. To guard against too much adverse selection, a minimum percentage of this section of the population is required, and the enrollment period is limited usually to 1 or 2 weeks at intervals of once or twice a year. The campaign is carried on through the active cooperation of civic organizations such as the local chamber of commerce, the men's and women's service organizations and clubs, and individual civic leaders.

The hospital utilization rate for persons enrolled on a community basis is higher than that for employed groups. One reason for this is that more people in elderly age brackets are allowed to enroll. Another possible reason is that unemployed people are sometimes unemployed because of the very fact that their health is not good. When enrollment is offered to persons in a large group, such as an entire community and if group enrollment requirements are low or are not applied, the normal tendency is to enroll a high percentage of poor actuarial risks. Those most likely to need hospital care will be the first to enroll, while those in the best of health will be the last.

As mentioned above, subscribers enrolled in community enrollments ordinarily pay their subscription dues to the plan individually. This of course makes for substantial extra clerical work on the part of the plan. One ingenious way around this was recently adopted successfully in the city of Magnolia, Miss., where the city government authorized billing and collection of Blue Cross dues along with the city water bills. Notice of Blue Cross dues is stamped upon each water bill and the subscriber remits to the city which transfers the total subscriptions to the Blue Cross plan. The economy of such an operation is evident.

Rural enrollment

Enrollment of farmers and others living in sparsely populated areas presents a special problem. Such people are not as hospital-conscious as are urban dwellers, and therefore a special effort in public education must be made. Employed groups are small and few. The scattered population makes difficult the billing and collection of subscription dues.

Blue Cross plans have used two principal methods in enrolling the farm population. One is to consider each family as part of the town or village and to offer enrollment on a community basis as described above. The other is to consider the farmers as a special economic group and to offer enrollment through their own organizations, such as the farm bureaus, the granges, the Farmers Home Administration (formerly the Farm Security Administration), farmers unions, cooperatives, and others. Cooperation on the part of the farm bureaus and their federations has been particularly effective. In a number of States, the Farm Bureau federations have assigned special workers to promote enrollment of their members.

Blue Cross plans in several Midwestern States have encouraged the formation of independent, self-governing county health associations. Working in cooperation with the farm organizations, these associations offer enrollment to all farm families. The subscribers' councils previously mentioned have served as effective enrollment agencies in some plan areas, notably in Kansas and Ohio.

Total rural enrollment in Blue Cross as this is written is estimated to be in excess of 2,500,000 persons.

Individual enrollment

In addition to enrollment through employed groups, communities, and farm organizations, an increasing number of Blue Cross plans are offering enrollment on an individual basis. This means that applications are accepted by mail or over the counter from individuals wishing to subscribe. When this was first tried by several plans about 10 years ago, the same contracts were offered as to group subscribers. It was found that a greatly disproportionate number of applicants were people who knew that they were in need of hospitalization. The utilization rate in one large plan, which enrolled a large number of such individuals, went so high as to endanger the plan's stability. Accordingly the plan had to cancel many of these contracts. Since then all plans have placed restrictions on this type of enrollment in order to keep the loss ratio from getting too much out of line. Restrictions at the time of acceptance of an application may include physical examination, statement as to former illnesses (with denial of benefits for hospitalization due to preexisting conditions), age limitation (usually 65 years), and others. Maternity care is often excluded from the benefits. The subscription rate is usually higher than for group enrollment. No recent survey has been made to determine the extent of this type of enrollment. However, it is known to be on the increase in certain areas.

BENEFITS

Blue Cross plans provide hospital service benefits. In general, "hospital services" mean those services which routinely appear on the hospital bill, as contrasted to services which appear on the doctor's bill. For the most part, the distinction is clear cut, but in the case of certain specialties there has been a great deal of controversy. These specialties include radiology, pathology, anesthesiology, and physical therapy. In the vast majority of hospitals these services appear on the patient's hospital bill, and the public has naturally come to look upon them as functions of the hospital. However, physicians specializing in these fields have insisted that they are medical services and that they should not be included among the benefits of a hospital service plan. (The extent to which they are covered by Blue Cross plans appears in a tabulation later in this chapter.) The great majority of hospitals own their own X-ray equipment, and pay their staff radiologists on a percentage or on a salary basis. The same is generally true for hospital pathologists and physical therapists. In many hospitals, anethesia service is performed by nurse anesthetists employed by the hospitals; in others by physicians employed on a full or part time salary basis. Thus the hospital assumes a degree of responsibility for these services, and all these are charged for on the patient's hospital bill.

The recent rapid growth of medical-surgical service plans offered in conjunction with Blue Cross plans is tending to resolve this controversy, with the inclusion of the above services as benefits under the medical plan rather than the hospital plan. Another solution has been to continue to offer these services under the Blue Cross plan but to designate them specifically as "medical" services.

The member hospitals of the Blue Cross plans contract with the plans to furnish certain services to subscribers, in return for which they are paid by the plan according to a contractual arrangement. The hospitals guarantee services to the subscriber, as indicated in the approval standards listed above. This distinguishes Blue Cross from commercial insurance.

The term "service benefits" means that the subscriber receives benefits in terms of hospital services to the extent of his contract and is billed by the hospital only for such services as are not covered under the contract. This is in contrast to cash indemnity insurance, under which the policyholder pays the whole hospital bill and then files a claim with the insurance company for cash reimbursement in the amount specified under his policy.

The service-benefit principle of Blue Cross works to the advantage of the subscriber in several ways. First, his Blue Cross card serves as an adequate credit reference upon admission to the hospital. Second, he need not lay out cash for the whole hospital bill and then file claim with the insurer, as in the case of an indemnity policy. Third, his benefits are usually more liberal than under indemnity, since certain hospital services are provided regardless of cost. Blue Cross plans frequently pay bills of several hundred dollars (sometimes thousands of dollars) for single cases. Such Blue Cross benefits as oxygen and penicillin in large amounts often run into hundreds of dollars on a single case.

Under the Blue Cross service-benefit contracts, hospital care is available to subscribers in member hospitals to the extent that it is needed, without being restricted to a limited number of dollars per day. This is important because no one individual can foresee when he will need care or what it will cost. The additional fact that 35 percent of all hospital cases are for 6 days or less (hospitalization expense is ordinarily highest during the first few days) makes most indemnity schedules inadequate to cover the bulk of such expense.

Factors which determine benefits

Blue Cross plans originate under local sponsorship, and the benefits and subscription rates are designed to suit the requirements of the particular locality of each plan. In general, benefits are available for most types of illness or injury except those covered by workmen's compensation laws. The specific benefits offered by any given plan, however, are determined largely by availability of the types of hospital accommodations in the plan's area, and by the demand for such accommodations on the part of the subscribers and potential subscribers.

Another factor governing the extent of benefits offered is the income level of the particular plan area. For instance, in the Southern States, per capita income is lower than the national average. People cannot afford to pay as much as can people in more prosperous areas. Consequently, subscription rates must be kept low and benefits must be restricted accordingly.

In the early years of hospital service plans, benefits were usually not provided for certain conditions such as tuberculosis, mental and nervous diseases, self-inflicted injuries, diseases not common to both sexes, and others. Experience showed, however, that when a sufficient sample of the population was enrolled, hospitalization for such causes constituted a negligible proportion of total Blue Cross utilization, and many plans now cover such conditions.

The general tendency of Blue Cross plans has been to offer more and more liberal benefits as the plan expands in size—aiming toward as complete a coverage of the hospital bill as is at any time actuarily feasible.

Summary of Blue Cross benefits

All Blue Cross plans provide for room and board, general nursing care, use of the operating room, laboratory service, routine medications and dressings, and use of the delivery room. Beyond these basic services, plans provide for various other special services. The tabulation below indicates several types of such services covered and the number of plans providing them in whole or in part:

Special diets	83	X-ray	61
Emergency room (in accidents)	81	Electrocardiogram	54
Anesthesia	73	Physical therapy	49
Basal metabolism tests	71	Pathology	46
Oxygen therapy	68		

Obstetrical care is provided by all plans under family contracts, normally with a waiting period of from 8 to 12 months. Some plans restrict the length of stay and others the extent of coverage on maternity cases.

Full benefits are provided for a period which varies among the plans but which averages from 21 to 30 days per contract year. Nearly all the plans provide partial benefits for an additional period, averaging about 50 percent of full benefits for an additional 90 days.

Regarding the extent to which the average Blue Cross subscriber's hospital bill is covered by his Blue Cross benefits, adequate data on which to base a national figure are not available. However, a recent survey of a small number of plans showed that when the subscribers to these plans used the room accommodation specified in their contracts, from 77 to 95 percent of the average bill was paid by Blue Cross.

TYPES OF CONTRACTS PROVIDED BY PLANS

Subscriber certificates generally fall into three classifications: One person, two persons, and family. There is a trend toward a two-rate structure, with elimination of the two-person certificate. There are several reasons for this: (1) Average utilization under family certificates is usually not very much greater (and sometimes lower) than under husband and wife certificates; (2) administration is greatly simplified: the certificate need not be changed when a child is added or dropped, for example.

The "family certificate" usually covers the subscriber, his wife, and all dependent children under the age of 18. In all of the plans, dependents are entitled to the same benefits as the subscriber, although in a few plans dependents must make a small daily payment to the hospital when hospitalized; the amount is usually $1 per day.

About one-third of the plans offer a "sponsored dependent" certificate. "Sponsored dependents" are dependents who live with the subscriber but who are persons other than his spouse or children. The subscription rate is usually the same as that for a single person.

INTERPLAN RECIPROCITY

The term "reciprocity" has been used somewhat ambiguously to refer to two separate and distinct sets of working agreements which exist among Blue Cross plans.

The first of these is the interplan transfer agreement, in which virtually all plans participate and which operates as follows: Each plan accepts the applications of paid-up subscribers of other Blue Cross plans who establish residence in its area, without regard to local enrollment requirements. Credit is given for the length of time such subscribers have been enrolled in their original plan, toward meeting any waiting-period requirements for benefits in the new plan. In addition, local employed groups which are branches of organizations with headquarters outside a particular plan's area are accepted for membership by that plan, even though smaller in number than regular minimum group requirements, provided that enrollment of home-office employees is proceeding or has been effected by another Blue Cross plan.

The second agreement involves reciprocity of service benefit to subscribers of plans who are hospitalized outside the area served by their own plan. Under this agreement, for example, if a subscriber of the New York City Blue Cross plan is hospitalized in Chicago, he is treated temporarily as though he were a member of the Chicago Blue Cross plan, and receives the same benefits in the Chicago hospital as would normally be provided a local member of the Chicago plan. The Chicago plan would pay for this care, and bill the New York plan for it. Experience with the system which has been in effect since 1945, however, has shown that its effectiveness has been handicapped by administrative difficulties, and that financial differences in hospital costs between areas has impeded acceptance of the program by many plans.

Reorganization of the system has been proposed by the Blue Cross Commission through establishment of a mechanism to be known as the interplan service benefit bank, and this program is scheduled to go into operation on May 1, 1949. The bank will act as a clearinghouse for out-of-area in-patient admissions in member hospitals of other plans, reimbursing the "host" plan the amount of its payment to the hospital for care rendered a subscriber of another plan, and charging the "home" plan (the plan in which the patient holds membership) an amount based on the cost of hospital care in its own area. Test studies have shown the financial basis of the bank proposed to be a sound one, and it is expected that establishment of the bank will result in rapid extension of the priciple of rendering benefits in terms of service to all Blue Cross members, wherever hospitalized.

BLUE CROSS SUBSCRIPTION RATES

As indicated previously, subscription rates vary considerably among the individual Blue Cross plans because of the variation in the cost of hospital service in different areas and because of other factors. A recent study showed variation in monthly rates as follows: For one person, from 70 cents to $2.10; for husband and wife, $1.30 to $3; and for an entire family, from $1.60 to $4.60. The national average monthly rates are: $1.25 for one person, $2 for husband and wife, and $2.75 for an entire family.

Space does not permit a detailed account of the numerous factors affecting the determination of a particular rate. However, a few of the most common will be briefly mentioned. As a base for a rate structure, the Blue Cross Commission estimated several years ago that approximately 8 percent of the population was hospitalized for acute illnesses in the course of a year, and that the average hospital stay was from 10 to 12 days. This means that the average person spent from eight-tenths of a day to 1 day in the hospital each year. On this basis, the commission recommended that Blue Cross subscription rates be high enough to cover every subscriber for 1 day's care per year, plus an additional amount for administration and reserves. For family agreements, the recommendation was for a rate high enough to cover 3 days' care per year. (Current percentage of population hospitalized and average length of stay are somewhat different from the above figures, but the latter will serve as an illustration of this theory.) To illustrate, suppose that a plan proposes to pay its member hospitals an average of $6 for care of its subscribers or their dependents. Suppose also that $1.50 is to be added for administration and reserves. The annual subsecription rate for a single subscriber would be $7.50. The rates for two-person certificates and for families would be correspondingly greater.

It is not meant to be implied that the above rule of thumb can be used indiscriminately. It is merely a starting point from which to build a rate structure. The utilization of Blue Cross benefits by subscribers varies considerably not only among the different plan areas, but also according to the type of group enrolled, as pointed out earlier. Not only the costs of hospital service, but also the costs of administering a Blue Cross plan, vary in different areas. Another factor affecting rate determination is the percent of income which a plan aims to allocate to contingency reserve. Changing economic conditions must also be considered. Many plans, founded during the depression of the 1930's, have had to raise their subscription rates substantially as a result of the current inflation. All of these elements must be balanced against one another whenever a particular rate is under consideration.

REIMBURSEMENT TO HOSPITALS

Payment by plans to member hospitals for services furnished to Blue Cross subscribers must fulfill two requirements: (1) It must be adequate to reimburse the hospitals for the expense they have incurred; (2) it must be reasonable, bearing in mind the responsibility of the plan to its subscribers.

There are three basic methods of payment in current use: (1) A uniform rate to all hospitals or to groups of similar hospitals; (2) differing payments based on each hospital's charges for service; (3) differing payments based on each hospital's service costs.

When there is a uniform rate, it is usually graded so that the payment is higher for the first few days of the hospital stay than for subsequent days. This is because the first few days of a stay are usually the most expensive. For instance, one plan pays its hospitals $15 for the first day of a case, $20 for a 2-day stay, $27 for a 3-day stay, then graded payments up to $91 for 14 days and a straight $6.50 per day for stays lasting more than 14 days.

When a payment is made on the basis of the established charges of a hospital, a few plans pay 100 percent of such charges, but it is more usual for a plan to pay slightly less than 100 percent, on the basis that Blue Cross saves the hospital collection losses on Blue Cross patients, and also that many Blue Cross patients would have been charity cases had they not subscribed to the plan.

Payment on the basis of hospital costs presents particular difficulties of administration. For one thing, the accounting methods used by hospitals vary greatly, even within the same locality, so that it is often difficult for a plan to set up a system of payment which will be equally fair to all of its member hospitals. Another trouble, now that Blue Cross patients constitute such a large percentage of all general hospital patients, is that payment on a cost basis tends to penalize those hospitals whose operation is most efficient and economical.

Recognizing the difficulties involved in setting up a fair system of hospital reimbursement, the Council on Administrative Practice of the American Hospital Association formulated, in 1946, a set of principles for the guidance of hospitals and plans. A few highlights of this set of principles are: (*a*) "Hospitals should not expect to receive rates of payment from Blue Cross plans for basic services provided to subscribers in excess of the cost of such services, cost to include an allowance for depreciation of buildings and equipment and allowances for other contingencies * * *" nor in excess of "100 percent of the average gross earnings at established rates for all private patients occupying similar accommodations in the hospital." (*b*) The basis and rates of payment should in all cases be negotiated between representatives of the plan and representatives of the hospitals, both groups having at hand the facts (financial and service data) necessary for enlightened decisions. (*c*) Both groups, as public service agencies, should bear in mind the needs of each other.

SOME LEGAL ASPECTS OF BLUE CROSS PLANS

The early enabling legislation in New York State has already been referred to. Other States passed enabling acts for nonprofit hospital-service corporations, which carried more specific provisions as to the authority of the State regulatory bodies as well as to the obligations of the plans. In 1938 the Blue Cross Commission and a committee of the National Association of Insurance Commissioners drafted a "model enabling act," which has had a considerable influence on subsequent legislation. In some States special enabling legislation has not been necessary; it was possible to organize nonprofit hospital service plans under the existing laws. Under whatever State laws they are organized, all Blue Cross plans are exempt from Federal income taxes, as they meet the requirements of "an organization for social welfare." They are subject to social security taxes.

PLAN GROWTH AND FINANCIAL DATA

The growth in enrollment of Blue Cross plans in the United States and Canada has proceeded at a rate during the past 10 years that is little short of phenomenal. On July 1, 1938, total enrollment was 1,942,294; as of December 31, 1948, it had reached 32,921,212. At the time of this writing it is estimated to be well in excess of 33,000,000 or more than 21 percent of the entire population. A table showing enrollment in each year follows:

July 1—	*Total participants*
1938	1,949,294
1939	4,034,146
1940	5,180,357
1941	7,015,177
1942	9,484,212
1943	11,739,196
1944	14,763,635
1945	18,793,580
1946	23,132,508
1947	28,330,166
1948	31,210,819
1948 (Dec. 31)	32,921,212

During the same period, the number of plans has increased from 40 to 90. This latter trend, however, has been offset to some degree by mergers of two or more plans and by the Blue Cross Commisison's policy of encouraging the formation of State-wide plans when granting first approval to a hospital service plan. Most of the newer plans are State-wide; where they are not, it is because local legal or other considerations make a State-wide plan impracticable. For instance, in Georgia there is a statute limiting a plan's area of operation to a circle of 50-mile radius from its headquarters city.

Blue Cross plans are now in operation in all but one (Nevada) of the 48 States, in the District of Columbia, in eight Canadian Provinces, and in the Territory of Puerto Rico.

There is considerable variation among the plans in respect to proportional allocation of the income dollar. However, the over-all average distribution, for the year ended December 31, 1948, was as follows: Paid to hospitals for care of subscribers, 85.34 percent; administrative expenses, 9.72 percent; retained for reserves, 4.94 percent.

There have been very definite trends in these averages during the past 6 years. From 1942 to 1947, the proportion of the income dollar paid to hospitals steadily increased, while amount laid into reserves underwent a corresponding decrease. Operating expense remained very nearly constant. In 1948 payments to hospitals levelled off, while operating expense dropped to an all-time low and amount laid into reserve increased correspondingly.

Percentage distribution of total income

	Hospitalization expense	Operating expense	Reserve funds
1942 (67 plans)	$74.60	$12.20	$13.20
1943 (76 plans)	75.66	12.40	11.93
1944 (73 plans)	76.22	13.30	11.48
1945 (86 plans)	81.37	12.29	6.34
1946 (87 plans)	82.34	13.01	4.65
1947 (90 plans)	85.62	11.14	3.24
1948 (90 plans)	85.34	9.72	4.94

ATTITUDE OF ORGANIZED LABOR

The role of Blue Cross and Blue Shield in relation to labor is increasingly important. Many welfare or group insurance plans negotiated as part of collective bargaining agreements include provision for Blue Cross or Blue Shield benefits, or both. The labor contract consummated between the Ford Motor Co. and the United Automobile Workers, which includes Blue Cross coverage, indicates the value which many important labor unions place on this type of coverage, as compared to commercial insurance company plans.

Blue Cross coverage is endorsed by outstanding trade-union leaders in the AFL and CIO, and Blue Cross benefits are an integral part of plans included in the collective bargaining agreements in the building trades, automobile industry, hotel and restaurant industry, furniture, electrical products, machine tool, rubber, and other industries throughout the United States.

Many Blue Cross plans have labor representatives on their boards of directors or advisory committees.

The participation of labor in providing Blue Cross and Blue Shield protection is also directly related to the question of Federal health insurance. Until very recently, almost all trade-union leaders have said that they were for Federal health insurance because they could not see any other way of providing their members with necessary benefits. But, increasingly, there is a recognition that Government standards are usually minimum standards, while voluntary plans, negotiated as part of collective bargaining agreements, offer the union leader an immediate opportunity to provide his members with better than minimum standards.

VI. The Blue Shield Movement

EARLY DEVELOPMENTS

The seventeenth century care prepayment plans in Montreal have already been mentioned, as have the plans of the late nineteenth century in lumber camps, mining camps, and elsewhere. Probably the first medical-care plan which can be described as a community enterprise, however, was initiated at the turn of the century in Tampa, Fla. This was the Centrol Espanol de Tampa, and it is still in existence. It was organized as a society not only to provide medical and hospital care but also for general welfare purposes. In addition to subscription dues, the society derives income from its social activities. It owns and operates its own hospital facilities. Medical care is provided by a panel of salaried doctors.

As the century progressed, other medical-care plans came into existence, particularly in the Pacific Northwest. Competitive situations developed, leading to certain abuses, and (as early as 1917 in the State of Washington) the county medical societies began to to take a hand, by the formation of "county medical service bureaus." The bureaus contracted with employers for medical care of their employees, and the latter had free choice among all participating physicians. These bureaus came into being chiefly in the 1930's. They gradually won general acceptance and there are now about 22 county medical service bureaus operating in the State of Washington. In Oregon most of the county bureaus have been merged into a State-wide organization; a few still function independently.

The first State-wide medical care prepayment plan was California Physicians Service, established by the California Medical Association in 1939. Complete physician's service was offered at a subscription rate of $1.70 per month. There was also a more limited contract available. Enrollment was limited to employed persons earning less than $3,000 per year. Physicians were reimbursed on a "unit" basis, the unit having a par value of $2.50 (the fee for an office visit), with other services being valued at multiples of this unit. Experience in the early years, however, was unfavorable, as demand for services far exceeded expectations, and the effect was to devalue the unit. So, beginning in 1941, all contracts were modified. This resulted in much more favorable experience, and the unit value now approximates par.

ROLE OF THE AMERICAN MEDICAL ASSOCIATION

In 1934 the house of delegates of the American Medical Association adopted a set of 10 principles for the guidance of medical service prepayment plans. Some of the more important of these principles were:

All features of medical service should be under the control of the medical profession.

No third party must be permitted to come between the patient and his physician in any medical relation.

The patient must have absolute freedom to choose any participating physician.

The confidential nature of the patient-physician relationship must be preserved.

Medical service should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

In 1938 a resolution was adopted endorsing "the principle that in any plan or arrangement for the provision of medical services, the benefits shall be paid in cash directly to the individual member."

During the next few years, a number of State medical societies developed their own voluntary prepayment plans. Service benefits were usually offered to subscribers within certain income limits; benefits in term of indemnity were also offered. Recognizing the virtues of the service benefit principle, the AMA house of delegates in 1942 approved "that principle of medical service plans on a service basis when sponsored by a constituent State medical association or a component county medical society in accordance with the recommendations relating to medical service plans adopted by the house of delegates."

In the following year the AMA established a council on Medical Service and Public Relations. Its functions were: To serve as a clearing house for information regarding adequate rendition of medical care to the American people; to study and suggest means for the distribution of medical service to the public consistent with the principles adopted by the house of delegates; to assist the State and county medical societies in their activities with relation to medical service.

The council formulated a preliminary set of "Standards of Acceptance for Medical Care Plans." Plans which meet these standards are granted the privilege of using the "seal of acceptance" of the Council on Medical Service. Some of the standards are:

Approval by the local State or county medical associations.

Responsibility of the medical profession for the medical services included in the benefits.

Free choice of physician.

Maintenance of the confidential patient-physician relationship.

Maximum benefits consistent with sound financial operation.

Benefits may be in terms of either cash indemnity or service units.

Sound enrollment and administrative practices.

Acceptance of plans by the council is ordinarily for " a period of 2 years or until revoked."

In December 1945 the house of delegates had instructed the AMA trustees and the council "to proceed as promptly as possible with the development of a specific national health program, with emphasis on the Nation-wide organization of locally administered prepayment medical plans sponsored by medical societies." In 1946 there was established a new central coordinating organization known as Associated Medical Care Plans, Inc., of which more later.

MEDICAL-SURGICAL PLANS AND BLUE CROSS

An overwhelmingly majority of the enrollment in successful nonprofit medical care plans has been carried on in connection with Blue Cross hospital service plan enrollment. This has been logical, since in most areas the Blue Cross plans were already established and were willing to make available their administrative experience to the medical plans. The degree of coordination, however, between local Blue Cross plans and their corresponding medical care plans varies considerably. The most common arrangement at present is for the two plans to have separate governing boards (and separate corporations) but to have a single executive director and administrative staff. Such an arrangement eliminates duplication of effort in enrollment and administration, and usually works out quite successfully. An even better arrangement is complete integration, with one corporation, one governing board, one executive, and one staff. This exists in only a few areas so far; its extension is hampered possibly by these factors: (1) Fear on the part of both the doctors and of the hospital people that the other group wants to control such a plan; (2) the fact that in most areas the Blue Cross plan was there first, and the medical plan is often not yet sufficiently well developed to command an equal share of public acceptance; (3) the fact that a number of States require by law that medical and hospital prepayment must be provided by separate corporations.

In some areas there is partial administrative coordination between medical and hospital plans, with separate corporations, boards, and executive directors, but with the hospital plan performing certain (not all) administrative services for the medical plan. In such cases the medical plan reimburses the hospital plan for its staff services, usually on the basis of a percentage of income, arrived at by mutual agreement.

At present (April 1949) 68 of the 90 Blue Cross plans are coordinated in one way or another with companion nonprofit medical-surgical plans, in 34 States, the District of Columbia, Puerto Rico, and five Canadian Provinces.

Because of their more recent origin, nonprofit medical-care plans have not yet been able to approach the total enrollment of Blue Cross plans. However, their growth to date has been just as rapid, if not more rapid, than was that of the Blue Cross plans in their early days. Total enrollment as of December 31, 1948, in all nonprofit medical care plans was 10,367,464, of which 9,537,819 were persons enrolled in medical plans coordinated with Blue Cross plans. A record of nonprofit medical care plan growth during the last 5 years follows:

Jan. 1, 1943	965, 000	Jan. 1, 1947	4, 436, 000
Jan. 1, 1944	1, 235, 000	Jan. 1, 1948	7, 328, 143
Jan. 1, 1945	1, 768, 000	Dec. 31, 1948	10, 367, 464
Jan. 1, 1946	2, 535, 000		

ASSOCIATED MEDICAL CARE PLANS (BLUE SHIELD)

As mentioned above, Associated Medical Care Plans, Inc., was founded in 1946 under the auspices of the American Medical Association, to serve as a central coordinating agency for voluntary nonprofit medical care prepayment plans. In general, its role in relation to the medical-care plans is analogous to that played by the Blue Cross Commission in relation to the hospital service plans.

Associated Medical Care Plans, Inc. (unofficially known as the Blue Shield Commission), as originally organized was connected with the American Medical Association because its origin constitution provided that three members of the commission must be members of the AMA's Council on Medical Service. The connection now (according to an amendment to the constitution adopted in October 1948) is that six members of the commission are appointed by the Council on Medical Service. The remaining commissioners are elected by the plans themselves, by district, in a manner similar to the election of the Blue Cross commissioners.

To be eligible for membership in AMCP, a medical-care plan must meet the standards of acceptance of the Council on Medical Service, referred to above, must be nonprofit, and must be in actual operation. Plans organized but not yet operating are eligible for associate (nonvoting) membership. The activities of the central organization are financed, as are those of the Blue Cross Commission, by dues from the individual plans prorated according to each plan's enrollment.

As of December 31, 1948, there were 60 Blue Shield (AMCP) plans, with a total enrollment of 8,995,021, in 34 States, the District of Columbia, one Territory (Hawaii), and two Canadian Provinces (British Columbia and Manitoba). About half of thse plans are State-wide, the remainder covering smaller geographic areas. The December 31, 1948, enrollment represents 87 percent of the 10,367,464 total enrollment in all nonprofit medical-care plans.

As for coordination with Blue Cross, of the previously mentioned 9,537,819 persons enrolled in medical-care plans affiliated with Blue Cross plans on December 31, 1948, 8,606,117 were Blue Shield plan members, or 90 percent.

As for distribution of the income dollar, the Blue Shield Commission issued a report as of December 31, 1948, covering the Blue Shield plans and eight other nonprofit medical plans. The combined average for all these plans was: Paid-in medical or surgical benefits, 77.58 percent; administrative expenses, 13.87 percent; added to reserves, 8.55 percent.

BLUE SHIELD BENEFITS

Under a straight service-benefit contract, the subscriber is entitled to such surgical (or medical) services as are included in the contract and as he may require, and he receives no bill from the physician. The physician accepts from the plan, as full payment, the fees for various operative or other procedures as established under his contract with the plan.

Under a straight indemnity contract, the subscriber receives cash or credit in predetermined amounts toward the physician's fee. The physician is free to charge the patient fees in excess of these amounts.

In point of fact, the most typical Blue Shield contract is one which is a combination of service and indemnity. That is, a subscriber whose annual income is below a certain amount (say, for instance, $3,000) receives service benefits, but a subscriber with a larger income receives only specified credits toward the doctor's total bill.

The service-benefit contract is generally the most favorable one to the subscriber, since he knows he is fully protected. One practical advantage to the doctor is that prepayment serves to cut down his collection losses. However, subscription rates must be kept down to a level generally acceptable to the public, and this may mean that the plan's income per subscriber will be insufficient to reimburse the participating doctors adequately. Another problem with service benefits is that it is often both difficult and awkward for the doctor (or the patient himself at times) to determine whether the patient's income is over or under the specified limit.

An indemnity contract eliminates these difficulties for the physician, and is generally to his advantage, since it puts a floor under his charges without establishing a ceiling. It is, moreover, simpler to administer. The subscriber, however, has no definite assurance of what proportion of the doctor's fee will be covered.

As far as enrollment is concerned, a relatively small number of subscribers have straight service contracts, a considerably larger number have indemnity, and a still larger number (about one-half of the grand total) have a combination of the two. No matter what the form of contract, however, subscription rates must be adjusted from time to time to meet changing economic conditions such as the rising inflation of the past several years. A contract which may seem fair 1 year may become quite unfair a couple of years later.

Since surgical procedures are usually more costly than medcal therapy (not only in themselves but also because they ordinarily require hospitalization of the patient), it is only natural that the medical care prepayment plans have emphasized coverage for surgeons' fees. However, there is a steadily growing tendency to include coverage for nonsurgical treatment, not only in the hospital but in the office and home as well.

It is customary to list, on the subscriber's contract, a number of the most common operative procedures, with the amount covered for each operation. Obstetrical care is usually included. Surgical-care contracts for the most part bear subscription rates about the same as or slightly less than corresponding Blue Cross hospital service contracts. Regarding the trend toward more and more comprehensive coverage, it might be noted that a plan will sometimes start out with a surgical contract, then offer a supplementary contract or rider to cover nonsurgical physician's services, and finally combine the two into a comprehensive contract.

BLUE SHIELD ENROLLMENT METHODS

Virtually all Blue Shield enrollment is carried on in conjunction with Blue Cross or other hospital service plans' enrollment. Usually, in fact, it is the Blue Cross staff personnel which sells Blue Shield. It is offered either to previously enrolled Blue Cross groups, or to nonenrolled groups in a combination package along with Blue Cross coverage. The advantages of coordination with Blue

Cross, from the standpoint of economical and efficient administration, have already been pointed out in connection with medical-care plans generally.

PAYMENTS TO PHYSICIANS

Agreements between Blue Shield plans and their participating physicians are characterized by three main features. First, the doctor agrees to abide by the rules and regulations of the plan corporation. Second, when there is a service-benefit contract, the doctor agrees to accept the plan's payment as full reimbursement for his services to a subscriber. Third, in most cases he agrees to accept pro rata payments from the plan in the event the plan cannot pay the full value of the service unit or of the indemnity; in this respect the doctor guarantees or underwrites the plan, just as Blue Cross member hospitals underwrite the Blue Cross plans.

Some plans which are on a straight indemnity basis require no guaranty on the part of the physicians; they merely pay the same indemnities to all physicians, in or out of their areas.

In the vast majority of plans, payment is made directly by the plan to the physician. Where it is not, the claim-report form usually provides for assignment by the patient to the doctor.

LEGAL STATUS OF BLUE SHIELD PLANS

In general, the legal status of Blue Shield plans is similar to that of Blue Cross plans. Most of them are organized either under special enabling legislation or under the general laws. The first legislation authorizing medical-care prepayment by nonprofit plans was passed in several States in 1939. Similar legislation has since been passed in a number of other States, in several of which the law permits one plan to issue both hospital and medical-service contracts.

In most States the medical plans, as well as the Blue Cross plans, are subject to supervision by the insurance commissioner. The degree or extent of such supervision arises greatly among the States.

Where the law permits a combined medical and hospital care plan, the provisions of the enabling legislation are substantially the same as those already described in connection with Blue Cross plans. Where the law provides for separate medical-care plans, the provisions follow the pattern of the hospital service plan law of the same State, except for sections dealing specifically with medical service. With a few exceptions, the medical plans are exempt from State and local taxation.

CONTROL OF MEDICAL-CARE PLANS

Where hospital and medical service prepayment is offered by a single corporation, the personnel of the board of directors, or trustees, is usually divided equally between the medical profession, hospital representatives, and the general public. In the more numerous cases where the medical care plan is a separate corporation, the doctors usually have majority representation on the board. A recent Blue Shield survey showed that the average composition of all Blue Shield boards was two-thirds doctors and one third laymen.

The administration of medical plans is of much the same character as that of Blue Cross plans. Enrollment, billing, and maintenance of subscriber records are usually handled for both plans by the same staff personnel. There is usually one executive director (virtually always a layman) for both plans. Most medical plans have a professional committee or a medical director, to review claims and arbitrate cases where there is a question as to the propriety of the fee.

After a participating physician has treated a subscriber, he sends the plan a bill or report of service. The plan checks the patient's status as a paid-up subscriber, records the service performed, and sends a check to the physician.

VII. Contrast With European Sickness Insurance Schemes

Most European nations have had some form of compulsory governmental sickness insurance for a generation or longer. The progenitor of the idea was Count Otto von Bismarck, who sponsored legislation in the German Reichstag which became law and went into effect in 1884. This and subsequent legislation of like nature were opposed by the Social Democrats, who felt that the whole scheme was an attempt to bribe the workers into complacency. The comment has been made that, as one means of coping with what was then considered a "radical" political movement in Germany, Bismarck conceived of social insurance as a substitute for government by the people—that he believed that the economically underprivileged, when offered a choice between liberty or security, seem to prefer the latter. Bismarck wanted to secure the workers' loyalty to the Hohenzollern dynasty by giving them something which they could not obtain by themselves. This was accomplished by setting the insurance premiums too low to pay for the benefits, and taxing the employers to make up the balance. The program was further subsidized at times with other government funds.

With various modifications, compulsory governmental "sickness insurance" or "health insurance" was later introduced into most other European countries (and into New Zealand, Japan, and two Canadian Provinces as well). To attempt to go into the mechanics or into the merits and shortcomings of these governmental plans would be beyond the scope of this chapter. It may, however, be pointed out that virtually all of them have one fundamental characteristic which is in direct contrast to the American nonprofit prepayment plans discussed in the foregoing chapter; the assessed "premiums" generally cover only a part of the total expense of operation; the balance is made up through government subsidies taken from other tax funds. The Blue Cross, Blue Shield, and other voluntary plans, on the other hand, stand on their own financial feet.

VIII. Current Problems

Most of the problems with which medical and hospital care prepayment plans have been confronted, and the means by which they are being worked out, have been mentioned in the course of this chapter. They include:

Extension of rural enrollment.

Coverage of certain special services such as radiology, pathology, and anesthesiology.

Provision of service benefits to subscribers hospitalized away from their own plan areas.

Adjustment of payments to hospitals and physicians in accordance with changing economic conditions.

Closer integration of medical and hospital-care plans.

Service versus indemnity benefits in medical-care plans.

Means of continually increasing economy of operation, so that more and more comprehensive benefits can be provided.

There is another problem which is of major importance and which, after a long period of trial and error, appears now to be on the verge of solution. This is in connection with the enrollment of employees of national firms (firms having branches in two or more plan areas). Such a firm naturally wants uniform coverage and uniform subscription rates for its employees in whatever part of the country they may be located. With the great variety of benefits and rates existing among the individual Blue Cross and Blue Shield plans, this has heretofore been impossible to arrange, except for a few instances where the plans involved in such a national account have agreed to modify their rates and benefits to some extent. National firms have been enrolled usually with each employee being entitled to the benefits of the plan in his local employment area. There has also been difficulty in the variation in enrollment regulations among the plans, in respect to minimum size of an eligible group, minimum percentage of applications required, effective dates of new contracts, and other procedures.

Some of these problems have been partly solved by the Blue Cross plans by the adoption in 1946 of a set of uniform enrollment regulations to apply to national accounts. Administrative difficulties have been encountered, however, and an entirely new approach has been developed, and approved by the Blue Cross Commission, by the American Hospital Association, and by the National Conference of Blue Cross plans. It will enable a national firm to obtain uniform benefits, uniform rates, and uniform enrollment procedures for its employees in any part of the country.

This will be accomplished by a national agency, operating through and supported by the plans, empowered to contract with national firms for provision of health services. Such contracts will provide uniform rates, benefits, and enrollment and billing procedures on any given national account. The agency will write excess coverage in areas where local plans do not provide all the benefits desired by the particular firm involved.

The agency will in no sense be a merger of the plans, which will remain fully autonomous. It will act only as an agent of each plan in matters pertaining to the enrollment of national firms having employees in the plan's area.

IX. CONCLUSION

The future of voluntary hospital and medical-care prepayment in the United States and Canada depends on the increasingly active support and cooperation of the medical profession, the hospitals, and the plans. The public demands comprehensive protection against the financial hazards of illness, and, in one way or another, the public will be served. Those of us who believe that such compulsory Federal Government programs as have been proposed in certain congressional bills of the last few years would defeat their alleged purpose, by spreading medical care so thin as to lower its quality disastrously, at the same time saddling the taxpayers with a hugely expensive political bureaucracy, will have to bend all our efforts toward making the voluntary system work so well as to refute all assertions as to its inadequacy, once and for all. If we do not do this, we may expect our lawmakers to yield within the next few years to the political pressures for a compulsory Government program, as has already happened in less fortunate nations. And when that happens, we may look for the eventual taking over by the Government of the Nation's voluntary hospitals, and for the end of the free practice of medicine.

To the CONGRESS OF THE UNITED STATES:

A BRIEF ON COMPULSORY HEALTH INSURANCE UNDER FEDERAL LEGISLATION

(By Kenneth C. Crain)

[From Hospital Management, January 1949]

It is proposed to examine in this discussion, in such detail as may be necessary, the following points:

1. The reasons advanced in support of the proposal for a compulsory health insurance system, and their fallacy, including the matter of rejections for selective service.
2. The fashion in which the present system of individual health care operates, as to both medical and hospital services; the care of those who cannot pay for such services, and the methods of arranging prepayment.
3. The record of Government-controlled health care, in this country and in others, including Germany, Great Britain, and New Zealand.
4. The cost of a compulsory health-insurance system under social security, and the difficulties already confronting social security and the taxpayer, without this added burden.

The above outline indicates that this is an attempt to place before the Congress, fully but as briefly as possible, all of the considerations involved in the proposal to adopt by Federal legislation a compulsory system of health insurance. The reasons advanced in support of these proposals will be examined, as well as the arguments against them. The subject not only deserves, but demands, the most serious attention of this Congress, because the Federal plan transcends partisan political considerations, and approaches the revolutionary in its theory and its probable effect upon American life.

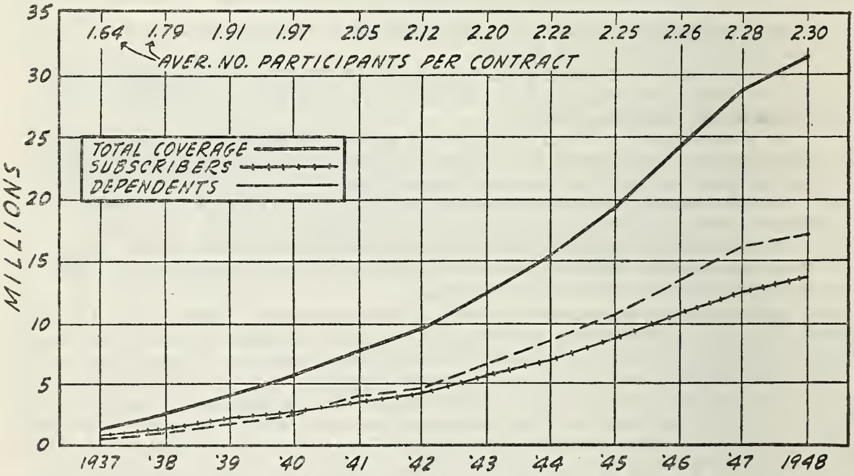
It should be emphasized at the outset, especially in the light of the necessity for the most careful examination of the whole matter strictly on its merits, that it was in no accurate sense subjected to a referendum of the people in the recent election. While health insurance was mentioned in the Democratic national platform and in the campaign, the 21-point legislative program submitted to Congress by the President in his message of September 6, 1945, which on November 16, 1948, he indicated still to contain what he termed the "main bearings" of the course of his new administration, conspicuously omits the subject. It might reasonably be inferred that some of the serious difficulties involved, financial, administrative, and ethical, led to this omission.

It is pertinent in this connection, moreover, without any attempt at detailed and controversial analysis, to refer to the fact that out of a total of around 95,000,000 possible voters, only 48,690,075 actually did vote, and that of this total about 24,100,000, or less than one-fourth of the possible grand total, voted for the winning national ticket. Under the American constitutional system, this decided the result; but it conferred no "mandate" for any purpose, and it would be the gravest injustice to the country to press for passage a compulsory health-insurance plan on the plea, so obviously ill-founded, that the people demand it.

Let us therefore examine the concept of a Federal compulsory system of health-care insurance, to see whether it should for sound reasons be enacted into law, or whether it should for sound reasons be rejected. This is the responsibility of the Congress to the whole people, as well as to the professional groups who have as their person and professional responsibility the care of the people's health.

THE ARGUMENTS FOR A FEDERAL PLAN

The reasons advanced in support of the idea of taking all individual health care under permanent Federal control have become so well known that it is necessary to refer to them only briefly. They rest upon the general assertion that the American system of care, with the free practice of medicine, dentistry, and nursing, and various types of hospital care, including especially the voluntary nonprofit community hospitals used by most people, while good in many respects, has become inadequate. They refer particularly to the fact that many people are unable because of limited resources to pay the costs of their health care, and therefore propose a compulsory insurance system to be paid for by Federal taxes levied upon all who work and their employers. They compliment the present extensive and rapidly expanding nonprofit and commercial prepayment plans, but, again, condemn them as inadequate. They appear to agree that the utmost possible degree of freedom, except the freedom not to be taxed for it, should under a Federal system be left to the individual citizen as well as to those who must render the required services, and promise that no real deprivation of liberty will result, whereas on the other hand they confidently assume a great improvement in individual health care.



The growth of Blue Cross plans over a decade.

An enormous mass of conflicting evidence, of statements pro and con, has been accumulated in the course of the attempts of Congress for several years to examine this subject in connection with the several bills which have been introduced relating to it; and undoubtedly many conscientious Members of both Houses have mined this mass for information. Eight volumes of reports of the hearings on the general subject of the so-called national health program before committees of the Seventy-ninth and Eightieth Congresses alone offer nearly 5,000 pages of material to the investigator, and search will produce valuable results. Some reference will be made later to specific material in these volumes.

The total is mentioned only to show how extensive and earnest the investigation has been. It is also true that a large part of the material consists of material from Government employees in the offices which would be greatly expanded in authority and power by the enactment of such a law, and there are also extensive contributions by some of the legislators strongly in favor of it. Numerous organizations with no actual knowledge of the subject have recorded their views, as well as representatives of organized labor and of the medical, hospital, and other professional and technical groups interested.

The scope of the proposal is virtually unlimited, in view of the present plan, which will have to be examined and converted into legislation in advance of the health-insurance idea, to extend the coverage of the social-security system to all who work, including the self-employed such as farmers, professional and small-business men, and members of the armed forces. Directly connected with this extension of social security is the conceded necessity for increasing the present painfully inadequate benefits under the old-age and survivors' insurance set-up which at present comprises a major part of the social-security system. The costs which this will involve are very large, and this and other aspects of the extension plan will be considered later in some detail. The scope of the health-insurance plan, in this light, would add to the social-security problem the individual health needs of the entire present population of about 147,000,000 persons, and the plan must be thought of in that light.

THE PRESENT SYSTEM OF INDIVIDUAL HEALTH CARE

How do Americans, for the most part self-supporting and self-respecting, see to their own and their families' health as things now are? Well, they must in the first place always use some judgment as to what to do, notably as to whether to visit or to call in the doctor, with such factors involved, stressed by the advocates of Federal care, as the nature of the illness, the accessibility of facilities, and the cost. Under a national health-insurance scheme the matter of cost would not be a deterrent, since the bill would go to the Government, with certain results which will be examined later. Accessible facilities would not automatically follow Government insurance and control, either, though this has been lightly assumed.

While it is true in some cases necessary care is at present not sought because of the cost, it is certainly also true that virtually everywhere a serious need is attended to by doctors and hospitals, regardless of the patient's abiliy to pay. This fact is not challenged. A survey conducted by Hospital Management in 1943 revealed no instance where a hospital would refuse to care for a person needing care, regardless of his lack of money. The free work done by most doctors as a part of their professional duty to the community is extensive but unadvertised, and is accepted as a matter of course.

MEDICAL CARE

The medical needs of the country are served by the largest and best-trained corps of physicians and surgeons in the world, of whom the great majority, about 140,000, are members of the American Medical Association, which is strongly opposed to working under a Federal compulsory health-insurance system. Other practitioners of the healing art, including dentists, may produce a grand total of 250,000, while registered nurses number about 435,000. These men and women are scattered all over the country, roughly in proportion to the population.

Some of them work for hospitals or other institutions, governmental or otherwise; but the majority of the physicians and dentists are engaged in private practice under what is known as the fee-for-service system. That is, they treat the patient according to his needs, and charge him as a rule according to his ability to pay; which means that in some cases he pays little or nothing, while in others he pays too much. The latter kind of case has impressed the average cautious citizen with the desirability of negotiating in advance in case of the danger of an excessive bill.

In general, it may be asserted that the system works. In defense of it, it may be stated with emphasis that it is a great deal better, both in the availability and in the quality of the services rendered than any other system in the world, and that it shines with special brilliance by comparison with the systems of care operated by government, here or anywhere else. One important point is that, contrary to the assertions which have been made by the advocates of Federal care, the number of physicians is increasing steadily, and at a more rapid rate than the general population. According to reliable authorities, 10 years ago there was 1 doctor to every 800 persons in the country. There is now 1 to every 760 persons, and by 1960 there will be 1 for every 700 persons. More physicians are being trained than ever before in the country's history. This situation is worth comparing with the recent British permission for a doctor to handle a maximum of 4,000 patients, under the national health service.

THE BLUE SHIELD PLAN

Medical men themselves have recognized the desirability of making it possible for the self-supporting citizen to provide for his medical care by some form of insurance prepayment, as bills have grown larger with the advance in medical knowledge and scope of treatment, and major surgery, with its unavoidably high costs, has become fairly common. The Blue Shield nonprofit prepayment plan was therefore inaugurated a few years ago, with the active sponsorship and cooperation of the doctors, and like Blue Cross, has grown so rapidly that it already has over 10,000,000 members.

Operating in effective liaison with the Blue Cross hospital-care plans, and in many cases administered and sold by the same organization, it promises eventually to make available to the whole country, at moderate cost, the opportunity to secure protection against the cost of medical care, as well as assurance by the doctors themselves, as sponsors of the plan, of the availability of such care. Of course, only the compulsion of a Federal statute can force people to buy medical and hospital-care insurance, and the widespread objection to such compulsion, enforced by an income tax in addition to all other taxes, is entirely sound.

This objection is characterized by the advocates of the Federal plan as "emotional," which it may very well be, since the American people have a strongly emotional feeling about their personal liberty; but it happens to be based on the principle of individual responsibility which is the very root of the American national character, and which will be lost or destroyed at grave risk to the country's future.

The doctors and dentists themselves are of course among the most vigorous opponents of Federal compulsion, to be exerted not only on them and their fellow objections are based upon a variety of sound reasons, some of which will be dealt workers in individual health care, but upon virtually the entire population. Their objections are based upon a variety of sound reasons, some of which will be dealt with in detail elsewhere.

The professional man is above all an individualist, or he would not enter work which calls for 10 years of intensive study following his secondary schooling, and for sufficient initiative thereafter to enable him, in the typical case, to select his location in some American community, settle down in it, and eventually to earn a living as an independent doctor or dentist. His objection, therefore, to being placed permanently under the intensive regulatory control of a Government bureau as to his practice, including who may and may not be his patients, his fees, records, reports, method of billing, and so forth, is easy to understand. He can point, moreover, to the fact that such a system has recorded unvarying failure in other countries.

He recognizes the desirability of aiding the public, including his own patients, to pay for his services, and for that purpose he has cooperated in the establishment of the Blue Shield plan. He does not want this plan controlled in any respect by others than doctors, and this, too, can be understood. He and his fellows are making this plan workable and generally accessible to the public, at reasonable cost. That is all that may properly be asked of him.

Has this system of medical care been the costly failure which is alleged by those who declare that only Federal compulsion can produce good health? On the contrary, American health is actually the best in the world. A current bit of convincing evidence is the recent report by a leading life-insurance medical authority, Dr. Louis I. Dublin, of the Metropolitan Life Insurance Co., indicating that the American people were never healthier than in 1948, and that prospects for the coming year are for continued improvement. The 1948 death rate established a new all-time low, with a figure slightly below 10 per 1,000 population, according to Dr. Dublin, despite such changes in the population structure as a large increase in the number of infants, on the one hand, and the proportion of old people, on the other, both tending to increase the death rate. Mortality rates in 1948 fell at every age level.

	General hospital		All hospitals			General hospital		All hospitals	
	Beds	Patients admitted	Beds	Patients admitted		Beds	Patients admitted	Beds	Patients admitted
1947	592, 453	14, 665, 195	1, 425, 222	15, 829, 514	1938	425, 324	8, 545, 930	1, 161, 380	9, 421. 075
1946	641, 331	14, 051, 508	1, 468, 714	15, 153. 452	1937	412, 091	8, 349, 773	1, 124, 548	9, 221, 517
1945	922, 549	15, 228, 270	1. 738, 944	16, 257, 402	1936	402, 605	7, 755, 848	1, 096, 721	8, 646. 885
1944	925, 818	15, 060, 403	1, 729, 945	16, 036, 848	1935	406, 174	6, 875, 182	1, 075, 139	7, 717, 154
1943	850, 576	14, 454, 638	1, 649, 254	15, 374, 698	1934	393, 425	6, 291, 556	1, 048, 101	7, 147, 416
1942	594, 260	11, 634, 288	1, 383, 827	12, 545. 610	1933	386, 713	6, 071, 512	1, 027, 046	7, 037, 982
1941	533, 498	10, 646, 947	1, 324, 381	11. 596, 188	1932	395, 543	6, 303, 573	1, 014, 354	7, 228, 151
1940	462, 360	9, 219, 496	1, 226. 245	10, 087, 548	1931	384, 333	6, 321, 861	974, 115	7, 155, 976
1939	444, 947	9. 018, 316	1, 195, 026	9, 879, 244					

The increase in hospital service from 1931 to 1947.

This is by no means a picture which condemns the present system of free medical practice and of independent community hospitals. Those who would risk the destruction of that system by deliberately enforcing its exchange for one whose unvarying record in other countries has been bad in every respect may be motivated by a real desire to improve American health; but they must nonetheless meet the suggestion that the methods which they propose appear to be founded on ignorance and a failure to understand all of the implications of their proposals.

THE SELECTIVE SERVICE REJECTIONS

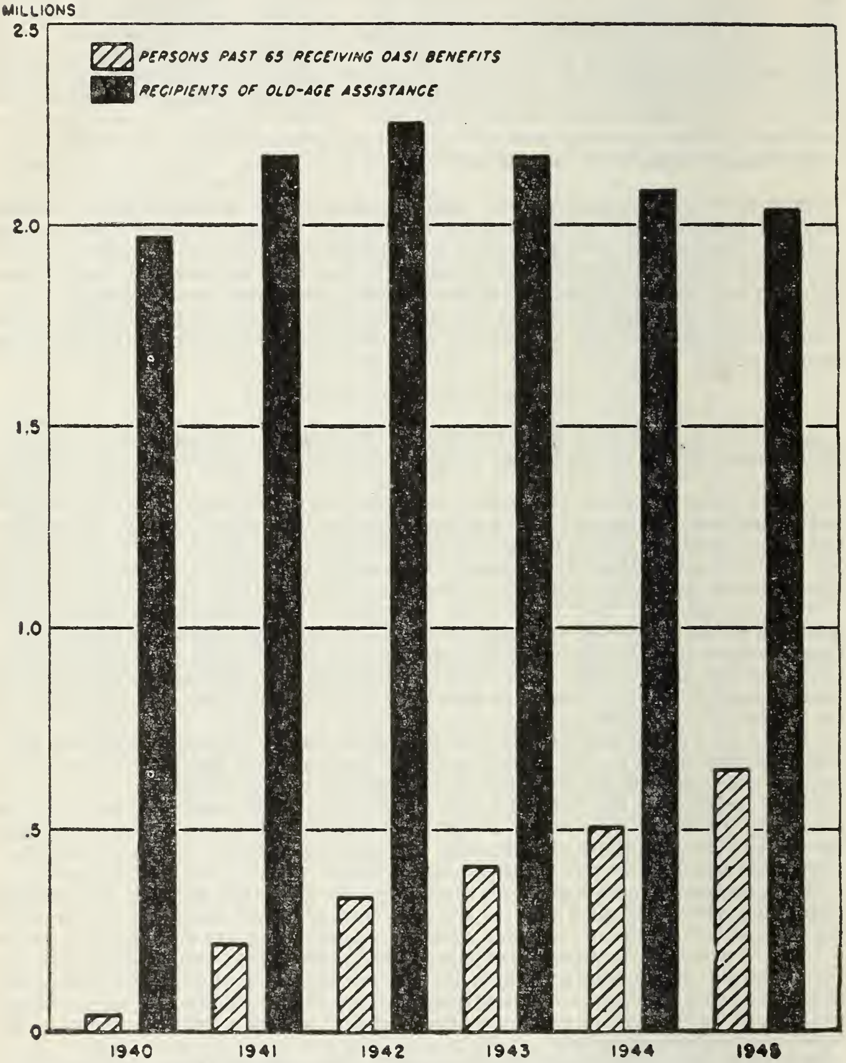
So much has been made and continues to be made, in many cases by those who should know better, of the alleged 5,000,000 rejections in selective service because of remediable defects, that the facts on this matter should be recorded here, in order that this false but persuasive argument may no longer have any weight with Congress. Conclusive and detailed evidence, by medical men of the highest character, has been placed before the Senate committees which in the past 2 or 3 years have been holding the exhaustive hearings referred to, to the effect that these rejections for remediable defects are several million less than charged, when analyzed, and that there is in the whole matter no relationship to the question of the character, cost, and availability of medical care. In fact, one of these medical men, Dr. Maurice H. Friedman, of Washington, D. C., pointed out that in many large groups of rejectees their handicaps, instead of being due to lack of medical care, were due precisely to the fact that they had had medical care. Said Dr. Friedman:

"In the first place, a great many of the defects discovered and listed have very little significance to health. That is not only my opinion, but it was repeatedly pointed out in the official bulletins of the selective-service statistics.

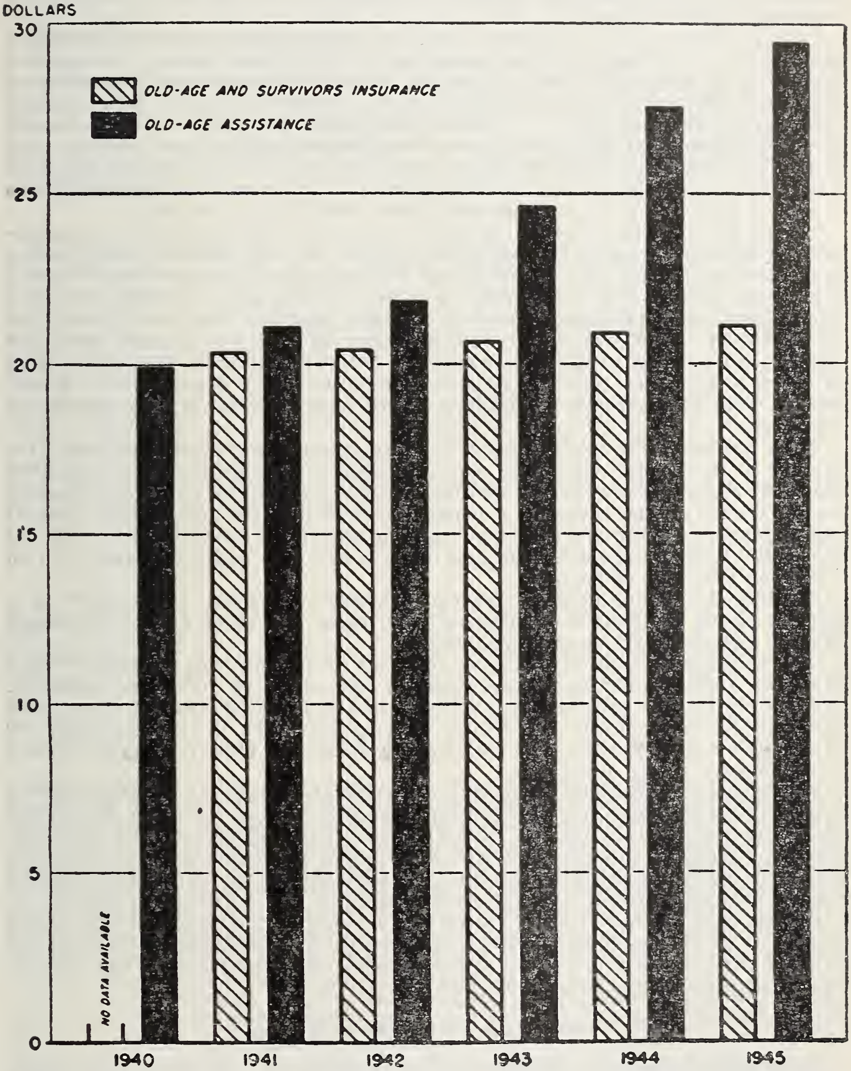
"Over one-half of the defects listed are structural abnormalities rather than diseases. They might be minor things. A man might have the tip of one finger knocked off or something of that sort. Of the remainder of all these defects, a significant number are related to education rather than to medicine or health.

"Considering only the structural abnormalities, it is a bit ironical that rather than being the result of a lack of medical care, many of these defects are the direct result of medical care. For example, amputations are frequently done as a lifesaving measure or for surgical or medical purposes. Amputations, therefore, are the kind of defect which is a direct result of medical care, not the absence of medical care. Surgical perforations of the middle ear are another example of a medical care which produces a defect for the relief of a disease. We have many other examples.

"The fact that diabetics live long enough to be registered by a draft board is only due to our medical services. They are then recorded as a defect. Every child with rheumatic fever nursed into adult life by skillful medical care will live with a defect. Every invalided infant who survives the tetralogy of Fallot by skillful surgery will increase the recorded number of rejectees. We might ask ourselves: Is a corpse healthier than a rejectee with diabetes?" (pt. 4, hearings before a subcommittee of the Committee on Labor and Public Welfare, U. S. Senate, p. 2129).



Comparison of old-age and survivors insurance retirement beneficiaries and old-age assistance recipients, end of fiscal year. This appeared in the Calhoun report to the Committee on Ways and Means, "Issues in Social Security."



Comparison of average monthly payments under old-age and survivors insurance and old-age assistance, end of fiscal year. This appeared in the Calhoun report to the Committee on Ways and Means, "Issues in Social Security."

Dr. Lowell S. Goin, of Los Angeles, Calif., appeared before the Senate Committee on Education and Labor on April 17, 1946, and made a statement on this and related subjects which is reported in part 2 of the committee's report of hearings, beginning at page 623. He pointed out many obvious factors contributing to the actual total of 4,217,000 rejectees which have no relation to the need for or quality of medical care, such as the inclusion of 444,800 manifestly disqualified, the armless and the legless, the totally blind, the totally deaf, and the life, with this comment:

"What medical care could have made this group whole? How shall the amputated leg be restored, and who knows how to cure optic disease? The modern concept is that mental disease is largely a constitutional inborn inability to cope with reality. What has medical care to do with it; 582,100 were rejected for mental deficiency. * * * Even a very slight knowledge of eugenics will persuade anyone that this group does not constitute a medical-care problem. Together, these three groups (idiots, imbeciles, low-grade morons) reach a total of 1,727,600, or more than a third of the rejectees. If they are now excluded, there remain 2,426,500, a little less than one-half of the famous 5,000,000.

"Three hundred and twenty thousand of these were rejected for musculoskeletal defects. That is the congenitally short leg, the clubfoot, the withered arm, the absence of a half vertebra, and the consequent crooked back. How, I ask, would medical care have restored these unfortunates to usefulness? Two hundred and eighty thousand were rejected for syphillis. Treatment for syphillis is offered freely everywhere. As a matter of fact, our statute books are simply loaded about syphillis prevention. I doubt that there is a community in which a syphillitic may not receive treatment from a department of public health. One wonders how compulsory health insurance would have eliminated this group.

"Two hundred and twenty thousand were rejected for hernia, probably for hernias so severe that the Army was unwilling to attempt repair. I mean by that that likely these were bad hernias, because I did think the Army repaired some. Hernia is the result of a congenital defect in the inguinal or femoral canal, presumably due to a defect in the germ plasm. If such a defect exists, its bearer is likely to have a hernia, and medical care has nothing whatever to do with the occurrence of hernia."

Pointing to the eye defects which are largely congenital, and computing a total of about 1,000,000 men suffering from these last three groups of defects causing rejections, Dr. Goin commented:

"The rejections which might be due to a lack of medical care are thus reduced to about 1,500,000, or about one-third of the shocking figure of 5,000,000. Although it is quite problematical whether any program of medical care would have altered substantially this figure, we may rest upon it, confident that the figures fall a good bit short of establishing an urgent need for the enactment of compulsory health insurance."

The detailed analysis by these brilliant medical men of the selective service figures destroys completely any save an imaginary basis in these figures for the Federal plan, and justifies the suggestion that any person who hereafter refers to them in support of compulsory health insurance does so either in ignorance or in bad faith. None the less, such references will undoubtedly be made. Informed Members of Congress will know how to evaluate them.

Medical care in these United States is not perfect; it is only the best in the world. It is, of course, not everywhere instantly available, without money and without price, to all comers; but it can be had. Its superiority to any government-controlled plan is literally beyond expression.

The American Hospital System

The hospital system of the country is essentially simple, but is not always fully understood, although the facts are authoritatively and in great detail recorded each year in the study published by the American Medical Association entitled "Hospital Service in the United States." Most of the figures referred to herein are taken from that work covering the year 1947.

For most people the only need for hospitalization arises in connection with serious illness, surgery or maternity. These cases are cared for in general hospitals, and it is in this category that the great majority of the group of community institutions known as voluntary nonprofit hospitals falls. In addition to these non-profit voluntary hospitals there are also general hospitals operated by various governments (Federal, State, county, city) and those operated by private owners for profit.

Since, as stated, it is the general hospital, regardless of ownership, in which most people receive needed service, it is these hospitals which handle much the greatest part of all hospital service, in terms both of numbers of patients and of patient-days of care. They handled in 1947 14,665,195 patients, who received 166,717,765 days of service, a handsome total for the 4,539 hospitals involved. That patient-day total is considerably over one hospital day for every man, woman and child in the country.

There is another large group of hospitals which cares for the chronic or long-term patient, the two largest classes involved being tuberculosis and mental cases. Typically these hospitals are operated by government, chiefly by the several States; and since for various obvious reasons the care of these patients has long been recognized as a governmental responsibility, this entire group of 1,737 hospitals is not taken into account in this study, nor is their 1947 record of 1,164,319 patients.

HOW ABOUT PAYMENT?

The question of payment for hospital care thus narrows down to the nearly 15,000,000 patients who were cared for in the general hospitals; and since it is this same question of payment, by or for the patient, which looms largest in the broad proposal that for all who work payment should be insured through a Federal tax, one point should be emphasized. It is that for the large number of patients cared for in the general hospitals operated by various governmental agencies the taxpayer pays. The patient in such hospitals (the Veterans' Administration hospitals, for example, or the typical city hospital) is virtually always there as the ward of the government operating the hospital. He is cared for without charge, therefore, in the proper discharge of the government's responsibility to him and to the community.

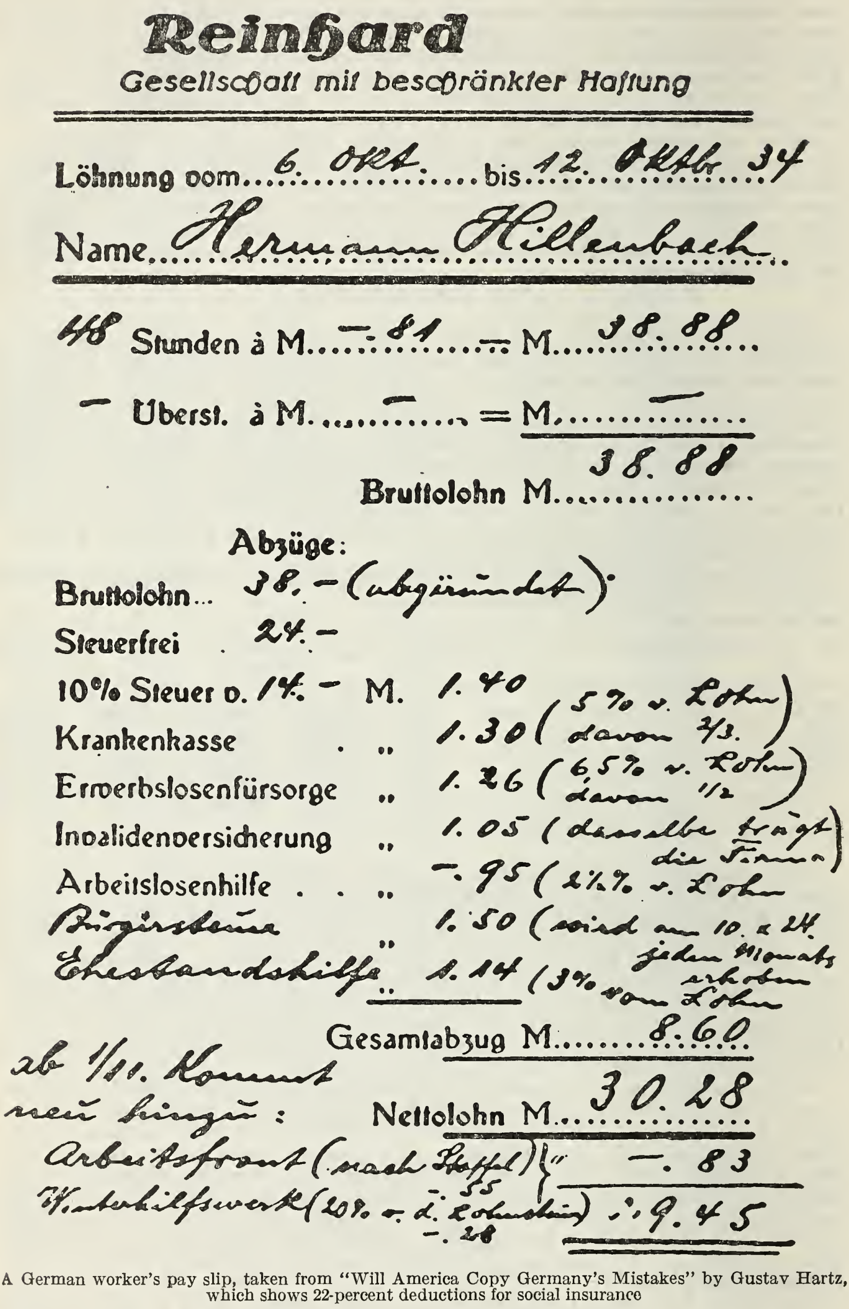
In 1947 the volume of general hospital care handled in these tax-supported hospitals ran to the following figures:

Government	Hospitals	Beds	Average census	Births	Admissions
Federal	317	132, 258	96, 294	46, 048	1, 179, 560
State	57	21, 599	15, 484	50, 134	353, 899
County	267	43, 994	32, 662	109, 332	717, 921
City	286	51, 736	41, 278	191, 539	1, 144, 613
City-county	42	8, 297	5, 958	32, 605	184, 429
Total	969	257, 884	191, 676	429, 658	3, 580, 422

These totals are impressive, esepecially when considered, as they should be, in relation to the fact that they relate almost entirely to the groups which cannot afford to pay for service in the voluntary nonprofit hospitals. This is true of very nearly all of these patients except veterans entitled to service without charge in veterans' hospitals because of service-connected disabilities. The entire costly and generally efficient system of tax-supported hospitals was established and is being continually expanded and operated for the purpose of caring for that part of the public with low or no income, including the group known as the medically indigent, which consists of the self-supporting to whom the cost of so-called catastrophic illness is too heavy a burden.

The care is universally accepted as a community responsibility, and in all of the larger cities and the more quickly populated counties it is met by the facilities of the hospitals established and maintained for that explicit purpose, as the above figures indicate. In addition to this extensive care for the patient who cannot afford to pay, the voluntary hospitals also provide a widely utilized service for the low-income group, free or below cost, with some payment either by the patient or from tax sources. Since it is largely to the group thus especially provided for that much of the concern expresesd by proponents of the Federal plan is directed, it is reasonable to suggest that the Congress take all of these facilities into account.

The fact is that while the plight of those who cannot afford to pay has been cited as one of the strongest reasons for the Federal plan, this plan would have a rather painful effect upon such of them as are employed to the extent which would subject them to the proposed gross income taxes, since they would



Reinhard
Gesellschaft mit beschränkter Haftung

Löhnung vom 6. Okt. bis 12. Oktbr. 34
Name Hermann Hillenbach

48 Stunden à M. -.81 = M. 38.88
– Überst. à M. – = M. –
38.88
Bruttolohn M.

Abzüge:
Bruttolohn ... 38.– (abgerundet)
Steuerfrei . 24.–
10% Steuer v. 14.– M. 1.40
Krankenkasse . „ 1.30 (5% v. Lohn davon 2/3.)
Erwerbslosenfürsorge „ 1.26 (6,5% v. Lohn davon 1/2)
Invalidenversicherung „ 1.05 (dasselbe trägt die Firma)
Arbeitslosenhilfe . . . „ -.95 (2½% v. Lohn
Bürgersteuer „ 1.50 (wird am 10. u. 24. jeden Monats erhoben
Ehestandshilfe „ 1.14 (3% vom Lohn

Gesamtabzug M. 8.60

ab 1/11. kommt neu hinzu:
Nettolohn M. 30.28

Arbeitsfront (nach Staffel) -.55
Winterhilfswerk (20% v. d. Lohnsteuer) -.28
„ -.83
9.45

A German worker's pay slip, taken from "Will America Copy Germany's Mistakes" by Gustav Hartz, which shows 22-percent deductions for social insurance lose this much of their inadequate incomes for the purpose of providing payment for hospital care which they now receive to a very considerable extent for nothing. The problem offered by these who have no income at all, the completely indigent, has not yet been given any considerable degree of attention by those who think that the Federal Government has a responsibility for the care of individual health. It is a subject which may be commended to the attention of Congress, and it is not in any necessary degree related to the imposition of a compulsory health-insurance plan upon those who are not indigent.

A factor which also deserves serious consideration by Congress is that which is involved in the Federal proposal to make eligible for care in other than Government hospitals, through compulsory insurance, many thousands who are now adequately and properly cared for in their local tax-supported institutions. These institutions, which are naturally jealous of their long-established function and of their place in the hospital field, must be taken into account from all of the angles involved. There will always be a need for their services, even under the Federal plan, but this need would certainly be diminished to the precise extent that low-income patients were unfairly taxed and then thrust into the voluntary nonprofit hospitals.

Should taxpayers everywhere, large and small, be asked to contribute through new and potentially unlimited taxes to a system which would to a considerable extent remove responsibility and control from local taxpayers? The answer may depend upon the point of view; but the American point of view has always been that local self-government, and local responsibility for the care of those in the community unable to look after themselves, are for every possible reason to be preferred to the distant authority and the distant tax collector.

The reasonable conclusions on the general subject are admirably stated in the Brookings Institute report of February 1948:

"The United States has some individuals and families not possessed of the resources to enable them to pay for adequate medical care. In the future, as in the past, provision must be made for them through public funds or philanthropy. The evidence suggests that many of them are elderly, impaired, or underendowed, or are widows or deserted women or their dependents. It is doubtful if they could be effectively covered by compulsory insurance because they would lack the means to attain and maintain an insured status.

"The large majority of American families have the resources to pay for adequate medical care if they elect to give it a high priority among the several objects of expenditure. The issue is not whether they can afford medical care, but whether they should be compelled by law to pool their risks and to give payment for medical care a top priority. The major alternative for people with ability to pay is to leave them free to determine for themselves what medical care they desire and whether they will pool their risks through voluntary arrangements." [Emphasis supplied.]

THE VOLUNTARY NONPROFIT HOSPITALS

The voluntary nonprofit community hospitals, as stated above, are those which care for most of the self-supporting population when hospital care is needed. They comprise the group most completely independent in every way, most characteristic of the American spirit in that they were in every instance founded by leaders of the community to meet the needs of the community; and they are virtually unanimous, in the same spirit of independence and community control in which they were founded, in their opposition to a Federal plan which would make practically all of their patients Federal patients.

The hospitals fall into two groups: the church hospitals and the local nonsectarian community hospitals. Their service in 1947 is shown by the following figures:

Type	Number	Beds	Average census	Births	Admissions
Church	924	130,653	109,648	946.158	4,454,767
Nonsectarian	1,578	167,390	131,686	1,118,280	5,297,145
Total	2,502	298,043	241,334	2,064,438	9,751.912

It might be added here that another group of general hospitals comprises those under private ownership, operated for profit, and performing a useful service in many localities. They number 1,067, and in 1947 served 1,332,498 patients, this very considerable number presumably paying their own way, with or without some prepayment assistance.

As the figures relating to the great nonprofit group clearly indicate, these hospitals, founded and operated as independent community services, and having about 300,000 beds, are actually carrying the lion's share of the general hospital load. Of the total admissions to general hospitals, 14,665,195, these church and nonsectarian community institutions handle, for example, just about two-thirds, as against the one-third handled by all other general hospitals, governmental and proprietary. Of the total of 2,837,139 births in hospitals of all types, their proportion is even higher—over 72 percent. Incidentally, official estimates declare that 82 percent of all live births in the United States in 1947 were in hospitals, as eventually of course it is hoped all births may be; but the present record is a magnificent achievement of the American system of hospital and medical care as it is, and eloquent proof of the fashion in which it is serving the people.

The patients in these hospitals are for the most part pay patients, sent by their physicians or surgeons. Some have private rooms, for which they pay more than actual cost to the hospitals, because they want complete privacy or some other aspects of luxury care. A large proportion, to an increasing extent Blue Cross subscribers, since these prepayment plans now cover the country, occupy beds in rooms with one to two or three other patients, where the charges are lower than for private rooms; and others are in the large wards, where many of them are cared for without any charge, or at rates considerably below cost. But all who enter the doors of these hospitals are cared for; and their doors are never closed.

For some people, notably those who occupy private rooms, the bill involved in the complex of services offered by the hospitals (bed and board, general nursing service, laboratory, X-ray, operating or delivery room) may be taken in stride. For most, however, either careful saving in advance of the contingency, or some form of prepayment is highly advisable. People save for vacations, for Christmas; they do not always save for serious illness or surgery, because these matters are not predictable, and of course are not anticipated with pleasure if at all. Nonetheless, the citizen who knows that accidents may happen and that death and taxes—especially taxes—are certain, is to an increasing extent taking care of the needs of his family for hospital care by some form of insurance.

Blue Cross plans and the commercial insurance companies offer various means of prepayment which are everywhere available, the latter also covering medical and surgical care, for which on a voluntary nonprofit basis the Blue Shield plans sponsored by the doctors are increasingly available. Taking into account all of the methods by which the self-supporting and self-respecting American may, exercising his own choice and consulting his own means, arrange for the insurance of his hospital, medical, and surgical care in case of need, over 61,000,000 persons are thus to some extent protected.

An estimate of the total situation might be attempted along these lines: Covered in some sort of prepayment plan, 61,000,000; indigent or medically indigent who actually received hospital care (1947 admissions to Government hospitals plus care in voluntary hospitals) about 5,000,000; able to pay without insurance protection, perhaps 10,000,000; total 76,000,000. Subtracting this from the total population of 147,000,000, that would seem to leave about 71,000,000, including heads of families and their dependents as well as the unmarried adults, or in the neighborhood of 20,000,000 families. It should not be forgotten, either, that included in the total population are the 24,000,000 persons who according to the recent Hoover report receive more or less medical and hospital care from the Federal Government. It is a question, therefore, how many members of the 20,000,000 families estimated above have needed medical or hospital care, or, needing it, fail to secure it, out of their own resources or from the facilities at their disposal as citizens. Roughly one in nine of the population actually did receive hospital care in 1947. In any event, only a relatively small fraction of the group would need the protection they had deliberately refused to provide for themselves; and in case of need the typical case is certainly that they are cared for—at their own expense, as a ward of Government, or as part of the free service accorded by the present system.

National income taxes and debt, 1929 to 1949

Year	(A) National income (in billions)	(B) Federal budget (in millions)	(B) As percent of (A)	Federal debt (in millions)	Year	(A) National income (in billions)	(B) Federal budget (in millions)	(B) As percent of (A)	Federal debt in millions)
1929	$87.4	$3,300	3.8	$16,931	1942	136.5	34,290	25.2	72,422
1933	39.6	3,900	9.9	22,539	1943	168.3	79,702	47.5	136,696
1934	48.6	6,011	12.3	27,053	1944	182.4	95,573	52.3	201,003
1935	56.8	7,010	12.3	28,701	1945	181.7	100,398	57.2	258,682
1936	66.9	8,666	12.9	33,778	1946	179.3	63,714	35.5	269,422
1937	73.6	8,177	11.2	36,425	1947	202.5	42,523	21.0	260,400
1938	67.4	7,239	10.7	37,165	1948	[1] 227.3	42,200	19.2	260,200
1939	72.5	9,027	12.4	40,440	1949 estimated	(220.0)	(45,000)	(20.5)	(260,200)
1940	81.3	9,297	11.4	42,968					
1941	103.8	13,765	13.3	48,961					

[1] Projected figure.

As to those of the working population whose incomes are so limited that it is said, with sympathy, that they cannot afford either to pay as they go or to pay Blue Cross and similar premium charges, they are to be compelled to pay Federal charges, which may count to 5 or 6 percent, or more, of their pay, out of their own pockets, in addition to all other taxes, whether they can afford it or not. Of this seriously illogical and self-contradictory proposal, more later.

THE BLUE CROSS PLAN

Speaking of prepayment arrangements, look at Blue Cross, because it is by all odds the most successful and popular of all hospital prepayment methods—guaranteeing the needed service instead of providing a limited cash payment—and because it is hospital sponsored and nonprofit. The total coverage of Blue Cross (United States and Canada) is now 31,841,136, of which total 29,468,675 are in this country. The growth of Blue Cross from 1937 to 1948, from 1,164,126 to the total indicated, is certainly responsible for the fact that during the same period general hospital admissions rose from 8,349,773 to 14,665,195. (See charts.) In 1947 Blue Cross plans paid the hospitals for services rendered to subscribers $211,392,000, covering 21,700,000 days of care.

When it is considered that this has been accomplished in about 12 short years, and that every State excepting Nevada is now represented in the roll of some 90 approved plans, it must be said at least that it is a remarkable and commendable achievement. Even "the enemies of Caesar must say this," and the Federal Security Administration's representatives have from time to time paid tribute to the accomplishment, which however they regret they must brand as inadequate, and which must, they feel, be wiped out by the compulsory blanket substitution of a Nation-wide Federal system.

They suggest some such employment for Blue Cross plans, thus rendered futile, as their use in collections or bookkeeping; but such suggestions need not be taken seriously. The enactment of Federal legislation setting up a tax system for the support of national health insurance would by necessary consequence destroy Blue Cross, for the obvious reason that nobody would need to be twice protected against the cost of illness, nor would anybody voluntarily pay twice for such protection. Blue Cross would be dead, slain by the deliberate action of the Federal Government. Surely Congress will desire to think of this long and seriously before signing the death warrant.

There is another factor, characteristically American also, which will have to be taken into account while universal health-tax legislation is being considered. It is the fact that organized labor (which in general officially favors the Federal plan because half the cost would be taken from the employer) is rapidly leaning not only to the idea that arrangements for health and retirement purposes are appropriate items in collective bargaining, but that Blue Cross gives the best hospital deal; as it does.

The United Mine Workers, for example, have been conspicuously successful in this respect, with a welfare tax per ton of coal mined which has produced a very handsome fund. Just as the pensions made possible by this fund ($100 a month) are very considerably in excess of the pathetic retirement payments of social security, its ability to provide medical care for eligible workers, through Blue Cross or otherwise, might well be much greater than that of even a Federal tax-based fund. Certainly the case for welfare arrangements in collective bargaining would be seriously weakened should a Federal plan be adopted, for here, again, the employer, who would have to pay both ways, would be well within reason in objecting to paying twice. Thus the Federal plan would inevitably tend to destroy welfare provisions arrived at through collective bargaining by organized labor, precisely as it would destroy Blue Cross and other voluntary plans.

An eloquent tribute was paid recently to the part which Blue Cross plans have played in enabling organized labor to bargain for protection against the costs of hospitalization, by Harry Becker, director of the social security department of the International UAW-CIO, Detroit. Mr. Becker said:

"What labor wants for the one out of four families who are going to have a hospital bill this next year is a slip on leaving the hospital with reads: 'Your hospital bill has been paid in full.' There was a time when this goal was 'sky pilot' thinking; but today this idea does not belong in the stratosphere—we have demonstrated that through collective bargaining we have a practical approach to the problem of financing on a prepaid basis full prepayment of the costs of hospital care for every workingman and his family. This demonstration has been made possible because of the kind of joint Labor-Blue Cross cooperation existing in such instances as the Michigan Hospital Service and the International UAW-CIO."

In the light of a very recent development, the completion of plans under which employers operating in more than one State will be able to enroll their employees in Blue Cross on a national uniform basis, if desired, as in commercial insurance plans, Mr. Becker's further remarks are especially interesting:

"As unions move into social security as a major collective bargaining issue we are looking to Blue Cross to take the next important step. This step is a national Blue Cross plan which will provide for universal coverage with the same standard of 'full payment' benefits for all of the employees of a single employer even though the employees may be living in a number of different States. This means Nation-wide cooperation among all Blue Cross plans to assure national coverage of workers, wherever they may live, when a national labor-management program is set up under collective-bargaining contracts whether negotiated in Detroit, Pittsburgh, or Los Angeles. Labor is expecting that Blue Cross will not delay taking this next step—now."

Blue Cross has taken this step, as stated, largely in direct response to the reasonable demands of labor for national Blue Cross coverage, with complete service contracts guaranteed (as they are) by the voluntary nonprofit hospitals who are the actual partners of Blue Cross. The destructive effects of a compulsory Federal plan would thus involve directly not only Blue Cross, but the results gained in its utilization in industry through collective bargaining for hospital-care arrangements.

Would this be wise, or just? Is it necessary? Is it desirable?

The Failure of Government Medicine

Henry, the young Virginia orator of the Revolution, remarked on an historical occasion: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know but one way of judging the future, and that is by the past."

This is a sound view. Holding up the lamp of experience, therefore, in connection with the question of whether under Federal control a compulsory system of individual health care should be imposed, and attempting as well as may be to judge the future by the past should such a system be established, several matters suggest themselves for consideration. One concerns the operation of hospital and medical care by Government, particularly by the Federal Government, in this country, and another concerns the operation of social insurance systems, including health care, in other countries, such as Germany, Great Britain, and New Zealand; all of which have furnished a record of experience in this line.

REMEMBER THE NAVAJOS?

In this country there is an exceptionally impressive example of Government medicine as it actually works, in the case of the Navajo Indians, as reported about a year ago to the Department of the Interior by Dr. Haven Emerson, one of the country's most widely known and experienced physicians, on behalf of the Association of American Indian Affairs. This report, which was widely publicized, covered in detail the disgraceful conditions prevailing as to healht among the 81,000 Navajos, wards of the Federal Government ever since their final conquest in the seventies.

Dr. Emerson's report stated that with grazing for their flocks arbitrarily reduced, also by Federal authority, the Navajos are existing on 1,200 calories a day, less than the Germans received immediately after the war; that many of them are so weak because of this inadequate diet that they cannot stand sustained exertion; that there is one social-service worker for the entire tribe; that more than 10,000 are eligible for old-age assistance, aid to dependent children and aid to the blind, but are not receiving these services; and that mortality rates are so high, resulting from the total or partial lack of the medical services they need and are therefore entitled to, that Government economy in this respect appears to be purchased routinely with Navajo lives. A tuberculosis infection rate 14 times the average of the country as a whole is one pointed index of the situation.

The number of hospital beds in the generally excellent institutions operated by the Bureau of Indian Affairs appears to be adequate; but roads are almost entirely lacking, and the Navajos do not possess cars. The situation, in brief, has been and remains perfect for the kind of active public and individual health care, outside of or in the hospital (including out-patient care), of which the Federal authorities think they should be given permanent and exclusive charge for everybody. But medical care, in particular, has hardly been given at all to the Navajos, the very special wards of the Government.

Appraisal of the situation somewhat belatedly, Congress had taken steps to remove this disgrace from the Government's continuing record of ineptitude in health matters; but the facts constitute an unanswerable challenge to the ability of a distant central Government to give even minimum health care to the Nation as a whole, since it has failed so miserably in this limited area.

Aside from this curious, significant, and depressing instance, and with the qualification that, of course, there are good hospitals operated by government, including the Federal Government, and without raking up old ashes—some not so old—to start fresh fires, it must be said that as a rule the voluntary nonprofit community hospital, of which this country fortunately has so many fine examples, averages very much better, indeed, than the Government hospital. There have been and doubtless still are some hospitals in the voluntary group which are not as good as they should be; but there have been among them no such scandals of corruption, mismanagement, and bad service as have risen to the horrified view of the public from the institutions operated by government at all levels.

It is not always remembered, as an outstanding example of an important aspect of medical care chiefly under Government control, that mental cases are almost entirely hospitalized in tax-supported institutions, State or Federal, and that the record of these institutions, for whatever reasons, has furnished the unpleasantly authenticated background for such recent studies as "The Snake Pit." As a leading psychiatric authority commented 2 years ago (Dr. C. Charles Burlingame, Hartford, Conn.) "For over a hundred years 95 percent of the practice of psychiatry has been state medicine," adding that "before going further along the road toward political handling of medical care, the people should demand that the ability of state medicine be demonstrated first in its present responsibilities." Said Dr. Burlingame further:

"Why ask for new worlds to conquer when the obligations already belonging to socialized medicine have been so scandalously neglected? Why ask for more when a concentration of all efforts and resources in this one field which is already the Government's offers the greatest single opportunity to bring health to the greatest number?"

There has been no adequate answer to this logical question, from any quarter.

The painstaking investigation of the veterans' hospitals, for example, by the American Legion and other organizations of former servicemen, occurred not too long ago for the memory to be quite fresh of the conditions which they revealed. The mess, once revealed, was finally cleaned up by the prompt and aggressive action of the new head of the Veterans' Administration and his able assistants; but the record of what miserable conditions had accumulated over the years, under complete and undisputed Federal control, should not be forgotten. The tendency of hospitals operated or in any sense controlled by government toward such conditions will always remain, for reasons which everybody understands. The curious thing is that, this being the case, there are people who are not only willing but anxious and determined, to turn over to governmental control, in the fullest sense of the word, all individual health care. Congress will have to consider with the utmost seriousness this tendency, which was explicitly referred to sometime ago by a great hospital authority, the late Dr. S. S. Goldwater, a personal friend of the late President Franklin D. Roosevelt.

Dr. Goldwater was commissioner of hospitals in New York City long enough to find out something about the effect of political control on hospital care. He spent the last years of his life as president of the vast Associated Hospital Service, the metropolitan New York Blue Cross plan, and, incidentally, in fighting bitterly the then new threat of a Federal compulsory plan. An an address on this subject, delivered in Philadelphia in 1942, the year of his death, he said:

"Local organization and control will produce the best results in hospitalization, and any Federal approach to interference with the fiscal affairs of hospitals, leading eventually to control by a central government bureau, would be a tragic affair for the people of this country. There is justification for the interest of a humane government in the question of whether hospital service has been made available on suitable terms to the great mass of the people, but this inquiry should also take into account the fact that the voluntary, locally directed hospital service plans have made Government intervention unnecessary.

"Assumptions that we must do as other countries have done, regardless of our achievements, are certainly not justified, especially in a country where freedom is valued and where the principle of local self-government is supposed to be sacred. Even the different sections of our country differ in various ways, so that an actually even performance, uniform everywhere, could hardly be secured if it were desired. I don't want it; we could have it only under strict Government control, and it would be on a level far below what can be achieved under the system we have been developing for so long and so successfully.

"Moreover, failure in a locality, if it must occur, is not the tragic thing that a country-wide failure would be. Hospitals must be left free to take such action as their communities require, without having to wait for approval from Washington based on imperfect knowledge of local conditions and needs."

Speaking specifically of hospital conditions under Government control, of which his experience in New York gave him ample knowledge, Dr. Goldwater said, with the utmost earnestness:

"My own experience in New York showed me how far short government hospitals can fall from the perfection which has been attributed to them. Perfect conditions do not exist anywhere, and even in New York, where as head of the city's hospitals, I worked under conditions as favorable as can be expected in government, the story has not been told of the impediments placed by government circumlocution in the way of anybody attempting to administer a large group of hospitals from a central office. *The system as a whole failed to accomplish what I had in mind for the city because of the onerous conditions under which government work of all sorts has to be done. It could hardly be otherwise if the Federal Government attempted to exercise any measure of control over the voluntary hospitals, as it would inevitably do, sooner or later, under the plans proposed by the Social Security Board.*" [Italics supplied.]

The fact is that not enough has been said about the tendency of medical service to degenerate under Government control, in this country as well as everywhere else. Dr. Goldwater's comments are to the point, and they are supported strongly by some 1946 remarks by Dr. Frank H. Lahey of Boston, the famous head of the Lahey Clinic who ran the system of medical officer procurement for the Federal Government during the war. After pointing to the fact that the great loss in medical care under government is the disappearance of quality competition, Dr. Lahey said, addressing a group of surgeons:

"Veterans' care is an example of Government-directed medicine. I say this with regret, because, after all, who is responsible for veterans' care? We are. It is only recently that we have shouted about it. We have known how bad it was, and we have not done anything about it. It has been under our eyes for years. I doubt if there is a surgeon here who has not been rescueman for a Veterans' hospital, and has undone and done over things that have made him know that the medicine and surgery in many of them were not good. It has been excellent in some of them, and therefore we must not damn the whole thing for a relative percentage. But the point is this: If you want a living example of Government-directed medicine look at the Veterans' Bureau as it was. It was Government-directed medicine at its worst. It is not fair to say that it was Government medicine as it will be under the present national program of veterans' care, *but it is an actual completed experiment of what a national program of Government-directed medicine did degenerate to. It is for that reason that I plead that it is so easy to promote a plan and not foresee its possible future consequences.*

"I should think that this country after its experience with trying to legislate morals and sex and an appetite for alcohol would have learned by now that there are some things that must come by evolution and education and not by compusion. *They cannot come by compulsion.*" (Emphasis supplied.)

The Congress will undoubtedly give evidence of this character, coming from men of great ability, wide experience, and unimpeachable standing, the thoughtful consideration which it demands; and in this connection, the personal observation of many Members of both Houses will stand them in good stead as to the quality of Government operation or control of various activities.

It is of course true that the Federal Government would not at first literally take over the operation of the voluntary nonprofit hospitals, although the British experience shows clearly that eventually that would have to be expected. It is asserted by those who favor the plan that it concerns only the payment of the bill, and that otherwise the people and the institutions rendering individual health service would remain precisely as now. Both President Truman and the Federal Security Administrator, among others, have declared that they do not wish to injure or interfere with the voluntary hospitals, and that a compulsory Federal plan would not do this.

Unfortunately, that view takes no account of the fact that with the payment of all medical and hospital bills, for everybody who works, in the hands of a Government agency, control would follow as a matter of inevitable direct consequence. It is not only that "he who pays the fiddler calls the tune." It is the fact that where a Government agency disburses tax funds it has a duty to inspect the goods or audit the services for which the funds are paid. Whether this duty is intelligently and ably performed or not, it must be performed, and the fact of its performance would constitute effective control.

The mass of Federal regulations having the force of law which would necessarily flow from the attempt to operate a Federal health-care plan would be enormous, detailed, explicit and crippling. The fees and charges allowed would be only the beginning. Every move of the patient, the doctor, the dentist, the nurse, the hospital admitting office and the rest of the personnel engaged in its necessary activities would have to be covered in detail, as would the whole record of many millions of workers and their employers. That is why estimates of the additional Government personnel run as high as 1,500,000, based on actual experience abroad indicating one additional employee for each 100 persons covered by the system.

There is actually no way under a Government system to avoid this. It has to be attempted, wherever Government payments and controls enter. It includes the inescapable fact that functionaries almost automatically try to broaden their scope and importance, regardless of efficiency and cost. It is always confusing and hampering and in the peculiarly and essentially individualistic work of caring for the sick it has always proved to be deadly. It is known as red tape. It repels the best type of professional man, and the simple fact is that any such system in this country would prevent the expansion and improvement of medical care, instead of aiding it, because the men who would make the best doctors would not under such a system choose to become doctors at all.

HENCE THE OPPOSITION

It is of course this consideration, with all that is implied in it, which accounts for the consistent and uncompromising opposition to any compulsory Federal health insurance plan of the American Medical Association, the American Dental Association, the American Hospital Association, the American Protestant Hospital Association, the Catholic Hospital Association, and innumerable allied organizations. They have in their meetings, at public assemblies, in the press and before committees of Congress, stated repeatedly and in detail the explicit and reasonable grounds on which they most earnestly believe that Federal compulsory health insurance would mean Federal control, and that Federal control would mean inferior service to the American people, at vast and unpredictable cost.

There is no question about this virtually unanimous opposition on the part of the professional and technical groups who under the Federal plan as now would have to do the work of caring for the health of the people. It has been urgently, eloquently, and repeatedly expressed. Why have the views of these people, who must be regarded as the only available experts in medical and hospital care and the means of paying for it, been so deliberately and extensively ignored by the advocates of the Federal plan? This is a question which demands an answer, if there is one.

In all other affairs where national legislation is considered, the advice of the people who know, the people who do the work, is not only sought but followed. In the legislation concerning farms and mines and factories Congress would consider itself, and would properly be considered, as failing in its constitutional function as representative of all the people, and in its duty to consult the facts and the wisest counsel on the situation, if it did not secure and act upon the views of the qualified and experienced workers in the field involved. Would a completely new and radical farm program be adopted by Congress against the advice and wishes of farmers and farm-organization leaders? Would a system of control and payment covering all coal mining be imposed under Federal legislation over the opposition of both mine operators and coal miners? Of course not. The questions are ridiculous.

But it has been proposed time and again, for reasons which on their face are entirely inadequate to support the idea, to impose upon the hundreds of thousands of experienced, able, and intelligent people whose lives are devoted to the medical, dental, hospital, and other individual health care of Americans a system to which they are utterly opposed, on what must be accepted as sound grounds. And this system, condemned as inefficient and costly by the professional and technical personnel most intimately acquainted with the whole subject, is also to be imposed upon the people as a whole, with all of the risks involved of inferior service and increasingly burdensome cost.

Would Congress be wise to do this, in any situation short of a national emergency? Should not the informed opinion of the whole group of workers in the field be consulted and heeded, even against the weight of whatever pressures and arguments may be brought forth by the Government and other interested groups supporting the Federal plan? Should not the unhappy experience of other countries, far gone in paternalistic and collectivist controls of all sorts, be sufficient in itself to bar such moves in a nation "conceived in liberty"?

Germany, a pioneer in "social insurance," Britain and New Zealand have all furnished examples of what happens under government control of individual health care, and these are worth a brief review, since it may give some additional warning against the dangerous folly of imposing a compulsory health-care system in the United States.

GOVERNMENT HEALTH-INSURANCE IN ACTION

The experience of other countries, ranging from that of Germany for over 60 years to New Zealand's much more recent but similar record, shows that—

1. Costs skyrocket to incredible levels, due to overuse and other abuses.
2. Those who render the service tend to become cynical and careless in their role of Government dependents, as users do in their desire to get everything they have paid for, and the quality of all services deteriorates rapidly.

An authoritative study of the German system by Gustav Hartz, a Berlin labor economist, was published in 1935 by the Pennsylvania Self-Insurers Association of Philadelphia, and its statement of the record has not been challenged seriously. Since the war began in 1939, the study is probably the best prewar examination of the German system before the Hitler regime consumed everything. It is of course a matter of historical fact that the beginnings of social insurance in Germany were made by Bismarck, probably for the purpose of defeating the Socialists by outdoing them in this respect. At any rate, the system was established.

A broad introductory comment by the author is worth quoting, since it applies to the whole idea of social insurance, where Germany's experience was so long and so discouraging:

"Of all the risks in social insurance only old age, death, and the number of dependents can be exactly established. These are therefore the only cases in which an unobjectionable actuarial basis and an unquestioned legal claim are possible. Everything else is hazy and uncontrollable."

Thus, with an average payment to those receiving old age or disability insurance of $7 per month, the system also produced a rise in the average number of days of sickness (inability to work) from 5½ to 28 per year. Some of the very human factors contributing to this result are described in the following language:

"The sick insurance provides the workman with medical attendance free of charge, with medicine and other necessities, and with an allowance. Anyone will at first sight consider this as a great blessing for the workmen as well as for national health. The reality, however, is very different.

"Dread of illness obsesses most people, and this has been pressed into a system 'illness made easy' by which the will to be well is strangled. The doctor is consulted a dozen times where once would be sufficient—the insurance pays. The prescribing of medicine, bandages, etc., is desired. When they have been obtained they lie about until they are no longer fit to be used and must be thrown away—the insurance pays. Besides, it is nice to get something in return for the premiums paid year in and year out. Excessive 'overdoctoring' is the result and fear of illness that shakes the will for recovery, the best aid to health. Pretenders and hypochondriacs are bred and the use of medicine becomes excessive."

As a result, efforts at regulation were naturally made, with the cause and the result of the situation reported in these words, following the comment that the "social budget amounted to 2,100,000,000 marks in 1913, but in 1930 this budget reached 18,000,000,000 marks":

"In the first months of the year the applications for cures to the disability and employees' insurances pour in because many are anxious to take their summer holiday at the expense of the social insurances. Matters soon made an extensive controlling system necessary. This ended in badgering all persons concerned. Patients are visited in their homes by controlling officials who have to convince themselves that the patient is really ill and not doing any work. The patients are therefore allowed certain hours for going out by the doctors.

"The sick insurance engages so-called confidential doctors who have to submit the patient to a final examination to see whether he is too ill to work. The results of such examinations are to a great extent startling. Here is one instance from among thousands: Two thousand and eight patients were ordered to appear for a final examination. Eight hundred sixteen of them at once declared their complete recovery; 289 were found to be well by the confidential doctor. So nearly 50 percent were not ill at all.

"The confidential doctor is, so to say, the medical policeman, who not only controls the patients but also his fellow doctors who are treating them. The genuine patient is justly indignant to find that the existence of his illness is doubted, and that he who has always paid his premiums regularly and has a right to demand conscientious attendance is considered a cheat.

"This system, together with the rest of the bureaucratic apparatus, has wedged itself between doctor and patient, completely destroying the patient's confidence in his physician, which greatly retards all recovery. The sound idea of sick insurance has become thoroughly unsound, and the harm it does far outweighs its advantages."

But here is the net result in terms to be borne clearly in mind when the modest cost estimates are heard for an American Federal social-security system expanded to cover all individual health care:

"Premiums started on a modest basis. The first were 1½ percent for the employee and three-fourths of 1 percent for the employer. *Today the entire premium averages almost one-fifth (20 percent) of the amount of the wages, and for miners it is nearly 30 percent.*" [Emphasis supplied.]

What right or logic is there in any assumption, by anybody, that results in this country would be different, either in cost or in the deterioration of service, should the United States in a supremely ironical about face follow Germany's old example?

AND IN GREAT BRITAIN—

It should be remembered that while health insurance was initiated in Great Britain in 1911, under David Lloyd George, with a system of pay-roll taxes to support it, the recent complete socialization of all medical and hospital care in that country discards all pretense of insurance, and makes individual health care something like a government monopoly, which incidentally stopped short only of taking over the Catholic hospitals. While this result may be assumed to be a part of the rapid trend toward state socialism in Britain, it may also be inferred that the first step, compulsory health insurance, leads by natural consequence to the last, government monopoly.

At any rate some dispatches from London since the new system went into effect are at least informative, and bear a strong family resemblance in their report of what is now going on there to what happened in Germany. For instance, according to the Journal of the American Medical Association's London correspondent, August 14, 1948:

"In their enthusiasm for medical socialism its advocates entirely overlook its draw-backs. In a letter to the Times a physician who has had much experience of it in the panel system shows how much time is wasted. At least one-third of his patients come in for no medical purpose at all. They come for certificates of a great variety or for the repeat of a prescription. Here lies the main difference between panel and private practice and the main reason for so much unnecessary work, which clutters up the office and prevents good work for those needing a physician's care. The private patient, having seen his doctor, can get his prescription repeated as often as necessary by simply going to the pharmacist, but the panel prescription can be dispensed only once. For every fresh bottle the panel patient must visit the physician to obtain a fresh prescription, wasting his own time and the physician's time. It may be asked: 'Why not make a new regulation abolishing the difference?' The answer reveals another draw-back of medical socialism. The panel patient gets his medicine free, and with the universal craving for a bottle of medicine of the hypochondriacs of the English masses, the waste which exists under the panel system would be multiplied."

Commenting on this situation, admittedly a disturbing proof of the unfortunately general eagerness to claim too much of anything that is offered without limit, Minister of Health Bevan is quoted as saying:

"Because things are free is no reason why people should abuse their opportunities. This is a very great test of the maturity of the British people, insofar as they used the resources of the medical profession at their disposal without charge. The general practitioner has a very great responsibility. Overprescribing can be as bad as underprescribing. Some general practitioners are very conscious of the impressiveness of the long lists of drugs in their prescriptions on the psychology of their patients. We want the general practitioner to prescribe what he believes is necessary, and put nothing in his way. *But we want to impress on him that it is not a good thing to evoke merely a psychologic response by prescribing too expensive drugs.*" [Emphasis supplied.]

"We want to impress on him?" A stern warning from the Minister of Health, himself not a physician, to all general practitioners, about prescribing "too expensive drugs?" This is indeed government medicine in operation. But, after all, with expenses going up and excessive use of both doctors and drugs recorded, naturally the Minister of Health is concerned at the situation, as well he may be. The reader is inescapably reminded of the pathos of Sir Stafford Cripps' weary restatement of the facts of life to the British unionists, when he pointed out that wages had to come out of production, and that wiping out profits entirely would add only 4 pence a week. or some such trifle, to wages.

It is reported that "the rush for spectacles has been so great that it has overtaken productive capacity," and that (this too according to Mr. Bevan) the number of prescriptions of all sorts dispensed has reached a phenomenal level, at a rate twice that under the former national health insurance plan. An annual total of 140,000,000 to 150,000,000 prescriptions was estimated in consequence. The demand for dental care, a comparatively minor item in the health system, it was thought, has reached a cost of over $600,000 a day, or $180,000,000 a year, as compared with the estimated cost of $28,000,000 a year. In brief, all of the estimates, of use and therefore of cost, were far too low. This is the sort of thing which must be taken into account in any reasonable effort, if indeed such an effort can be made reasonably, to estimate the cost of complete individual health care in this country.

Among the resulting complications, entirely aside from the matter of the effect on Government finances, now substantially supported by contributions from this capitalistic land, is the overcrowding of all afacilities, with some consequences of the most tragic sort. It is a curious reflection on the operation of a compulsory health-care system in England for 37 years that it did not produce by direct result enough hospital beds, enough doctors or enough dentists for the country. Thus a question anxiously placed before the legal department of the British Medical Journal, according to its issue of November 22, 1947, growing out of the grave shortage of hospital beds after 36 years of compulsory health insurance:

"Question. A. B. is referred by his medical attendant to a particular consultant at a hospital. A diagnosis of early carcinoma of the stomach is made and confirmed. The patient is advised to have an operation, to which he agrees, and he is put on the waiting list for admission. Presumably the consultant has entered into a contract with the patient and his doctor to carry out the treatmen. The patient is not admitted for 6 or even 12 months, *and the growth becomes inoperable.*" [Emphasis supplied.]

The legal obligations involved are not such, the Journal's expert is said to have advised, that any liability results, since "neither the consultant nor the hospital is required to do the impossible." But the patient, it must be assumed, died without the benefit of the surgery which might have saved his life. Perhaps such a case could occur in this country, but the odds are against it. American hospitals, voluntary and tax supported together, rendered in 1947, 444,288,585 days of patient care, and handled in addition at low or no charge over 40,000,000 out-patient calls, where dangerous conditions calling for further treatment, including surgery, can be caught in time. In this country if a bed is needed for a serious case, the bed is there. This does not appear to be so under the highly socialized British system. So much for government control.

Still, there is something to be said for the national health service, compelled, both by the excessive and unnecessary demands which free service always produces and by the same inadequacy of facilities which under similar handicaps would certainly appear in this country, to let a cancer patient dies when he might have been saved. It has recently been announced that the Ministry of Health, no doubt after consulting both its financial situation and the demands of the public, is issuing an average of 200 utility toupees weekly, at a cost of $40 each. To meet this demand for the toupee as an indispensable health adjunct, 23 wig-makers, participating gleefully in the scheme, are working night and day, with an estimated total potential production of approximately 100,000 wigs. That is $4,000,000; and another $400,000 out of the apparently unlimited resources of the national health account (if not unlimited why this absurdity?) will be devoted to the cost of cleaning wigs for those beneficiaries fortunate enough to have two, since one of these may be cleaned and dressed at Government expense every 2 months. Wigs are supplied by the Health Ministry in all sizes and colors, and women are offered five different models.

But people wait until they die for hospital beds; and this, too, is government medicine.

AND IN NEW ZEALAND

In this small and highly socialized country, with a homogeneous population (except for the remaining native Maoris) which it might be supposed would have a fair chance of avoiding the major difficulties of placing all medical care under government control, 7 years of experience have shown once more that there are no exceptions to the rule of increased cost due to excessive use of all facilities, and decreasing standards of care. So serious, in fact, have these and related defects in the system become that the government and the medical profession are earnestly attempting to arrive at some practical revision of the program. Meanwhile the major problem facing government and people is indicated by the single simple fact that the tax bill for medical services rose from less than $8,000,000 in 1942 to over $20,000,000 in 1947. The cost of drugs rose from $2,000,000 in 1943 to over $4,000,000 in 1947. Thus the medical-care program contributes a growing share of the social-security budget, which is now one-third of the national budget, and therefore of the total tax load.

Moreover, while reports indicate that many doctors, and not by any means the best or the leaders of the profession, were earning fantastic incomes by vigorous exploitation of the system, both the profession as a whole and the public have found it unsatisfactory. A striking omission from it, also, is that even the excessive cost being experienced does not cover the cost of major surgery, the most serious burden to the average citizen, and the one which he is typically most anxious to cover through some form of insurance. Medical care, hospitalization, and drugs are the items covered.

A chief complaint in New Zealand is related to the fact that while all may resort to the doctor at will, with most (but not all) of the cost covered out of the insurance fund, there is no way of making the doctor stay in his office on holidays, week ends, and at night. This is attributed in part to the fact that there is no incentive for the doctor to work harder or longer because of his own income taxes, as well as to the amount of work forced upon him during the week. The demand for medical services tripled from 1941, when the system was put in force, to 1945, while many doctors were still with the armed forces, and there were not enough at home to meet the demand. When the war was over, with the demand for care still rising, the costs rose to the serious level referred to. Whether the government will find a solution satisfactory to its financial advisors as well as to the public and the medical and dental professions remains to be seen. Suggestions from the government to the doctors, in a semi-confidential vein as contrasted with its promises to the public, of reduced care, were properly rejected by the doctors. Recall Mr. Bevan's peevish comment about excessive use of expensive drugs in Great Britain. These systems seem to work the same way everywhere. That is to say, they produce excessive use, a correspondingly serious and unwarranted drain on the contributors and the government finances, and unsatisfactory service.

The present American system shines brightly by comparison with anything they have or have ever had in medical care in Germany, in Great Britain, or in New Zealand.

THE COST OF A FEDERAL SYSTEM

There is literally no way of finding out what the proposed compulsory Federal system for the care of individual health would cost, especially when the inevitable tendency toward excessive demands on the "free" services promised is considered. Estimates may be made, however, and these of course should be based upon such facts as are available, and not upon sheer optimism or a desire to make the prospective bill seem less than it will probably be.

Even with the health-insurance plan in mind, or perhaps with it especially in mind, the first necessity confronting the Congress is that of framing the legislation under which the coverage of the existing social security system will be expanded to take in the groups not now included, among which are the farmers and other self-employed, members of the armed forces, and the employees of nonprofit institutions. This, it is estimated, will produce a total under the system, including dependents, of about 120,000,000,000 persons, or 85 percent of the population. This is to all intent universal coverage.

At the same time the problem is to be faced, as it must, of making the system meet more nearly, if possible, the broad promise of "social security" implied in its title, by providing benefits which are not so low as to compel the "beneficiary," as at present, to apply for old-age assistance in order to avoid starvation. On this there is no argumuent whatever, as the facts on the OASI payments now made speak for themselves, and the Federal Security Administrator was very recently quoted to the following effect: "Today the average amount of old-age insurance paid to elderly couples is $39.30 per month. The present scale of payments was fixed in 1939, but since then the cost of living has increased nearly 75 percent, and the cost of food over 100 percent. Today old people who are entirely dependent upoun their social security payments are actually enduring slow starvation."

That estimate of the situation is not exaggerated. It should be added, moreover, that in the case of the elderly couples mentioned, unless both man and wife are over 65, which of course is not always the case, the only payment is to the man, and that its average is now around $25 a month. No such amount would have furnished as much as a bare subsistence in 1939, either, so that even then the promise of "security" under the system was a delusion. The delusion has merely become more evident with the increased cost of living. The whole situation has been recorded in immense and painstaking detail in "Issues in Social Security," the report of the Calhoun social security technical staff to the Committee on Ways and Means, ordered by the 79th Congress. None of the facts can be disputed.

That is all emphasized for the attention which it powerfully demands from Congress, not only because it happens to be true, and because the proposed remedial legislation will heavily increase the individual's and the Nation's tax burden, but because it offers an immediately relevant and striking proof of the failure of Government performance to live up to the glowing promise. Here as elsewhere in the world, the promise is broad, the performance is meager, and while the cost go up and the burden on the economy increases, the individual is progressively deprived of any chance to protect his own future. Meanwhile the control of government becomes steadily greater as its provision for its wards becomes more difficult and more expensive.

FIGURING THE TAXES

The present social-security tax of 1 percent each on employer and employee will have to be increased immediately to not less than 1½ percent each on a base of $4,800 instead of the present $3,000, according to the Social Security Board's own figures. The self-employed, including farmers, may be let off with a tax of only 1½ times the employer rate, instead of double, as it should be, so that this group would be asked to pay 2¼ percent of income up to $4,800 for the present system, providing only OASI and related benefits.

These taxes, chiefly for retirement benefits, on a grossly inadequate basis even if the proposed 50-percent rise is approved, are estimated to produce over $4,000,000,000 a year instead of the present $2,750,000,000; and they will add to the present $10,000,000,000 reserves in the system about $2,000,000,000 a year, up to the time when payments will exceed income, with the growth of the number of beneficiaries, and the Government will have to pay about one-third of the total out of general taxes to be levied on all alike. The Board's own estimates, again, point to an annual cost for the OASI system of $5,000,000,000 to $6,000,000,000 in 1960, $7,000,000,000 to $9,000,000,000 in 1970, and $9,000,000,000 to $12,000,000,000 in 1980. It becomes clear, as these figures are considered, that it really makes little difference how the taxes are levied, since all will have to bear them in one way or another, and the so-called reserves are in simple fact only Government obligations, for the payment of which, when cash is needed, the Treasury will have to provide.

Add to this, then, the proposed health-insurance system. The Board estimates its cost in the first year at $4,000,000,000, with an additional $2,000,000,000 should a disability insurance coverage be provided. These estimates appear to be in line with a conservative view of limited use of medical and hospital-care facilities, but not at all with the generally recorded fact of excessive use, when the Government is compelled to make good on its promises of unlimited care and medicines for everybody. In Great Britain, for example, in spite of the country's experience of 37 years with health insurance, the cost of the Government's operation of all health care was underestimated for the first 3 months alone at the rate of $872,000,000 a year. An equivalent error in similar estimates in this country, on the basis of relative population, would mean over $2,500,000,000 a year; which might matter.

However, taking the estimates as a basis, at least, of the tax which will in the beginning be asked of Congress for health insurance alone, with increased rates later as rising coests force the issue, 1½ percent each for employer and employee will be added to the social-security taxes, and, presumably, for the self-employed another 2¼ percent, all applying to pay or self-earned income up to $4,800. Thus for the farmer who can be shown to have netted that amount and there are a good many of them, there will be a gross income tax, in addition to all other taxes, of $216 a year—at the beginning. At the higher rates which will almost certainly become necessary as time goes on, the tax will be proportionately higher.

Thus at the very least and lowest, and without taking into account the depressing indications, in the experience of other countries, that health-insurance cost will be double or triple the highly conservative estimates, the Social Security Board itself believes that taxes will have to be levied annually for its operations, in addition to all other taxes, to the amount of not less than $8,000,000,000, with $2,000,000,000 more for disability insurance. That makes $10,000,000,000.

The Congress is to be faced immediately, aside from all this, with the tax and other problems related to a general budget of $45,000,000,000 or thereabouts. The tax bill which will be drawn to meet that enormous sum, without repeating the dangerous resort to deficit financing, will necessarily rely chiefly upon individual and corporate income taxes. These taxes, burdensome as they are when raised to the levels designed to meet such vast budget figures, will receive the most earnest scrutiny from Government experts, including Members of Congress, concerned both for their effect upon the general economy, especially upon industrial productivity and employment, and their impact upon the individual taxpayer.

With the country's now extensive experience in meeting enormous Federal governmental costs at least in part by taxes—the debt of $250,000,000,000 has accumulated in addition to taxes and remains as a continuous threat—realization has become general that there are no "new sources of revenue." The only source of revenue is the American citizen. He pays and will continue to pay the entire bill, in his daily expenses, in his production, in the effect upon his and his family's standards of living and their arrangements for the future, as well as in direct taxes.

He has been paying in direct taxes for "social security" purposes his half of the current take of $2,750,000,000. Under the new plans for the expansion of the system, not including health insurance, he will be asked to pay half of the increased levy of $4,000,000,000; and yet the payments to the OASI beneficiaries, it must be remembered, will remain so small (50 percent over the present average would be $37.50 a month) as still to force the lucky recipients to accept old-age assistance or stop eating.

Then ask him to pay half of an assessment of another $4,000,000,000 for health insurance, whether he wants it or not, and whether he needs it or not; and still another $2,000,000,000 for disability insurance. Ask him.

There is no need to doubt that many of the proponents of the idea of the Federal Government assuming full charge of individual health care, as of individual "security" in old age, mean well. But to mean well is not enough, if the results should be disastrous in terms of promises not kept, of the encouragement of abuse of medical facilities, the degeneration and discouragement of the profession of healing, and rising taxes and Government debt. Even the supporters of the Federal plan estimate an eventual cost for the program of somewhere between 15 and 20 percent of pay rolls (Readings in Social Security, Cohen & Haber). The Congress will have to bear all this in mind in attempting to decide wisely whether to embark upon a course so radical, so costly in both money and in the human factors involved, and so unlikely to accomplish the desired results, if experience both in this country and elsewhere means anything at all.

SUMMARY

The reasons advanced in favor of expanding the social-security system, admittedly a failure in its operation up to now, to cover individual health care, are not sufficient to warrant the serious risks involved.

Government plans for individual health care in other countries have produced uncontrollably excessive demands upon doctors, hospitals, and auxiliary services, without any possibility of reasonable check once the deterrent of individual cost has been removed, and with resulting excessive cost to the insurance fund and to Government.

Medical, hospital, and related individual health services in this country are now the best in the world, under a system which has developed according to the best traditions of the American character; and these services are available to the vast majority of the people, at charges they can pay with or without the increasing scope of voluntary prepayment plans, or without charge. Government may assist, but should not be permitted to destroy, this magnificent system.

Something must be said, in addition to all of the above, of the destruction of traditional liberty which is directly and unavoidably involved in the plan to bring individual health care under government control by compulsory legislation. There is a point at which the right and the duty of government to legislate, even for the general welfare, conflicts with the right of the citizen to be let alone. "Stop" signs are necessary on the public highways; but no citizen would permit them to be placed by government on his private road.

The parallel alleged between compulsory health insurance and compulsory school attendance is not accurate. School attendance is required of children, not adults; and it exists only under State law, not under Federal law. When every citizen is required not merely to submit to heavy deductions from his pay for Federal health insurance, but to call upon his doctor and his dentist on such dates as may be fixed by the Federal authority, the parallel will be complete, and the compulsory system will have developed to its logical conclusion. Such compulsion as to visits for medical and dental examinations is in fact the only possible way in which the results promised may even hope to be achieved. Will Congress go this far?

Under the still free American system, education of the individual to the desirability of proper professional advice on health matters, so that he may himself voluntarily take advantage of the available facilities, including prepayment for health care, is the only sound and practical and acceptable method.

Liberty is still the dearest possession of the American. Liberty always implies responsibility; and the exercise of responsibility develops ability to meet it, in every aspect of existence, including the care of one's health. The alternative of destroying personal and professional liberty is the alternative of the paternalistic and collectivist state. It is unacceptable to the traditions and the spirit of a free people. It should not be imposed for the purpose of taking over the control of individual health care or for any other purpose.

(Senator Murray submitted the following personal statements and other materials for inclusion in the record:)

(By Senator Murray)

In order to be quite fair to both sides, those who oppose and those who support national health insurance, I should like the record to show that I quite agree with some of the sentiments expressed by Dr. Mattingly, an opponent of national health insurance, in the letter that follows regarding the American Medical

Association's action in ostracizing Dr. Maurice Fishbein. From my point of view, I think the organized medical profession has dealt a grossly unfair blow to the man who, for years, was the most able representative of the ultraconservative group governing the AMA.

I wonder whether the removal of Dr. Fishbein from his state of power and authority really means a change in AMA policy. But whether it does or does not, I certainly doubt if the AMA will ever have a better public-relations expert. It was Dr. Fishbein who claimed and succeeded in winning for the AMA practically all of the credit for the achievements of modern medical science.

To have heard or read what Dr. Fishbein said would lead people to believe that America's leadership in the world in terms of health and medical progress is attributable almost solely to the achievements of doctors in the private practice of medicine. Credit for the tremendous progress that has been made in controlling communicable diseases, in extending the average life span, and in discovering the wonder drugs and other remedies for disease—much of which was accomplished through the work of laymen engaged in research and the efforts of doctors on salary in our Public Health Service—seems to be claimed by private practice. No matter who was responsible, where or under what circumstances, Dr. Fishbein turned the spotlight of fame and glory upon the heads and shoulders of doctors whom he represented in the AMA. No; I doubt whether Whitaker and Baxter or any other public-relations team can or will do for American medical practitioners what Dr. Fishbein was able to do while he was their loyal servant and recognized spokesman.

[From the Washington Evening Star, June 29, 1949]

"HUMILIATION" OF DR. FISHBEIN SEEN AS PRELUDE TO "RELICS" AND "TRACTS"

To the EDITOR OF THE STAR:

The recent Atlantic City convention of the American Medical Association was decision day for organized medicine. Our house of delegates made three crucial decisions purposed to stay the threatened socialization of the healing acts: It sternly rebuked a symbol of alleged reactionary leadership of our unpopular past; it gave a new concept of strategy and leadership a noisy vote of confidence; it settled for any home remedy that could survive local politics despite solemn promises of a truly national solution of our urgent health insurance needs.

Dr. Fishbein was made the official scapegoat for all the sins of reactionary leadership in our unpopular past. Muzzled and shackled, we delivered him to his many enemies as hostage for our good intentions. If a scapegoat can stay the compelling hungers of all mankind for collective security against bankrupting health hazards, Dr. Fishbein is presumed to fill the bill. His severest critics must admit he rose to power and prestige in the void created by spurned leadership. Practicing doctors were too busy or too indifferent to its exhaustive demands to wear its mantle of inevitable power. Dr. Fishbein took that spurned by lesser men and created professional prestige which envy changed to a deadly occupational hazard. This was because nature endowed him with the brilliant mind and aggressive ego inseparable from superior performance. He is one of the few doctors who could retire to a bare, cloistered cell and emerge with every essential of medical science reduced to written authority. He was guilty of assuming his social views were as authoritative as his learned discussions on any phase of medical science. Now he is leveled to the low estate of compulsory silence and the impotence of official emasculation.

VICTORY FOR "NEW LIBERALISM"

I frankly confess I was one of those who felt Dr. Fishbein's reactionary views on social science were harming the medical profession. But there was something sickening about the way we masters of healing executed judgment. I saw him on several occasions in Atlantic City. He was a lonely figure who accepted his unaccustomed ostracism with dignity and any act of friendship with touching gratitude. But what sickened me were the cynical remarks made by former admirers after he passed. Dr. Fishbein's public humiliation may have been a triumph for the new liberalism in medicine. But it was a far greater victory for antisemitism. Doctors should remember that pretensions to even-handed justice only are convincing when purged of the malice of envy and revenge.

I was present as a visitor in our house of delegates when our new leadership was introduced and given a noisy vote of confidence. The top-strategy planners for our survival as a free profession are not doctors. We who revolted at politicians invading the Nation's sickroom now have a husband-and-wife publicity team directing our strategy. Miss Baxter is going to stop the socialization of medicine with a holy relic: By keeping politics out of Sir Luke Feldes' picture of "The Doctor," she seriously proposes to satisfy our growing hunger for solvent social security within the framework of true democracy.

Miss Baxter's husband, Clem Whitaker, is the atomic task force of our new public relations. With the fervor of an evangelist, he exhorted us about things done and to be done. If he missed a single suffocating cliche, it was not for lack of time. An eloquent and persuasive spokesman for British doctors grudgingly was given 5 minutes to tell his story and he gave socialized medicine the most effective debunking I have ever heard by reciting chapter and verse of its greatest failure. Mr. Whitaker took much longer to say infinitely less. When he was through, we gathered that Oscar Ewing would never socialize medicine as long as Whitaker and Baxter had $3,000,000 to spend on tracts, holy relics and stamps. As a family doctor I have never been much for cure by testimonial. Whitaker and Baxter did not change my mind.

LOCAL DISSIDENTS GIVEN POWER

We always have preached a "national" solution of our health security problems. The term "national" implied equal social justice and security for all under an impartial rule of law. Our house of delegates substituted a rule of men for our professed ideal of a "national" rule of law. It gave local dissidents with their prejudices and hates the power to veto any plan they disapproved. Instead of courageously prescribing one national remedy efficacious for all, our AMA repudiated our profession's most sacred quest; that is, a specific remedy for any disease. This has been our ideal because we know a specific remedy will heal everybody, and place. Likewise, every doctor knows that a multiplicity of alleged remedies is a frank confession that we have none.

The AMA 'has lent its prestige and authority to a gun-shot prescription for healing a serious disease. That prescription changes its healing standards as it crosses each State line. The miserable and helpless are left more hopeless than ever. Instead of courageously assuming leadership in healing this Nation's wounds, our AMA has abandoned all pretense of wanting it.

As Dr. Fishbein was the repudiated symbol of our old reactionary leadership, Whitaker and Baxter are symbols of the new. We have turned healing over to publicity experts. In the future if you are sick, listen to your radio and don't forget to open your morning mail. "Doctors" Whitaker and Baxter may be sending you a sacred relic or a magic tract.

THOMAS E. MATTINGLY, M. D.

(By Senator Murray)

I want the record to contain some of the testimony on the need for national health insurance that has come to my attention spontaneously from individuals all over the country.

Here are a few of the many unsolicited letters I have received. These letters clearly show that this problem of paying for medical care is not confined to the so-called low-income families. Many of the writers say they are earning three to five thousand dollars, well above the average earnings. Yet, in every case the cost of medical and hospital care has constituted an acute problem, even where they have voluntary health insurance protection. In fact, the bulk of this testimony is to the effect that the American Medical Association is selling a false bill of goods when it claims that adequate voluntary health-insurance protection can be purchased for 62 cents a week. It is neither adequate nor is it only 62 cents a week.

Some of these people have become so accustomed to hearing national health insurance called socialized medicine that they have adopted the phrase. But judging from these letters, when people know what national health insurance would mean to them, they are for it by whatever name.

DURHAM, N. C., *June 25, 1949.*

Senator JAMES E. MURRAY,
Senate Office Building, Washington, D. C.

DEAR SENATOR MURRAY: * * * I was especially interested in the running comments of the president of the AMA in the recent issue of Look on your article on this subject. I should like to know where a complete private health insurance coverage can be had for 62 cents a week, as he states. My wife and I pay $30 a year for hospital coverage alone, and during the last 4 years, in every hospitalization, we have found that the illness was not covered by the policy. This has been the experience of several of my friends, so that we are beginning to wonder if these policies are not largely a waste of money. * * *

LAKE ODESSA, MICH., *June 17, 1949.*

DEAR SIR: I am taking the liberty to write you in regards to socialized medicine as Dr. Sensenich calls it. I am reading the article in June 21, 1949, copy of Look magazine. Dr. Sensenich states you can buy voluntary nsurance for 62½ cents a week covering surgical, medical, and hospital care; that would be $32.55 a year for one person. I have the Blue Cross doctors' plan of Michigan—surgery, medical, and semiprivate hospital, and the plan does not cover the full bill; it pays only a certain amount, all over that the patient pays. My wife had to have a private room; it cost $10 per day. I paid the difference. Now this so-called doctors' voluntary plan which the Dr. Sensenich says is so good costs me and the wife $22.45 every quarter, or $89.80 per year, and still we do not have full coverage. The plan you advocate would not cost a person near as much. * * *

PASADENA, CALIF., *June 20, 1949.*

Hon. Senator JAMES E. MURRAY,
United States Senate, Washington, D. C.

DEAR SENATOR: I have read with much interest your article in this issue of Look for June 21, 1949. I heartily agree with you in every respect. However, the main reason I have taken up my pen is to contradict the erroneous statements of Dr. Sensenich.

I am a member of a California physicians and surgeons service and the Blue Cross here in California. According to the doctor's own affirmations (it is their own plan) this is the best voluntary plan offered today—while it may be the best, I would like to point out the extreme inadequacy of this plan. (1) It costs almost $100 a year to me at $7.95 per month, and not 62½ cents a week, or $2.71 a month, as Dr. Sensenich affirms a voluntary plan would cost the individual. It is true that the present plan I subscribe to provides full hospital care for me and my family up to 21 days. After that I can receive it for one-half cost up to 180 days. However, I am only covered by physician service after my second visit, and my doctor can charge me what he likes above the fee he will collect from the physicians service because between I and my wife (we both have to work to make ends meet) our income is $5,000 gross (about $450 off for taxes alone from that). My wife and two children are not covered for disease, etc., at all—only surgery by the doctor—and also subject to any superimposed charge he wishes. Now that my boy is 19, and not regarded by them as a dependent, despite the fact he will cost me twice as much to send him through college—he will be dropped as a dependent with no subtraction from the $7.95 rate. I receive no dental care for my family (last year's bill was about $200), also no optometry service, maternity care, home nursing, laboratory service, unless hospitalized.

I receive no physical check-up despite the fact that doctors advise that any man over 40, especially under heavy business strain, should have a yearly check-up—I have recently had one at a cost of $35, but there was no way to cover this under the voluntary health plan.

Unless a building caves in on my family, or they get run down, or break something, they will receive no assistance under a supposed full coverage voluntary plan from a private physician. Obviously if this best of plans is so spotty and inadequate, what must the rest be like? Good luck and God speed you for a very necessary social forward step for the United States.

ASHEVILLE, N. C., *June 15, 1949.*

Senator JAMES E. MURRAY,
Washington, D. C.

HONORABLE SIR: I have just finished reading your article in the Look magazine, and it has inspired me to make this response. I am not a letter writer. This is my first attempt at expressing my views in this manner, but I felt compelled to say how much I agree that we should have some sort of medical insurance.

My family might be considered of the middle class and consists of my husband, myself, and two teen-age children. We have a moderate income of $80 per week, and we can just barely live on it; we have no savings. I am thankful to say that we are in pretty good health, all things considered, but each of us needs some sort of medical care which we are unable to afford.

For instance, I had a serious operation some years ago and was advised to have a yearly check-up. I haven't been to a doctor in 4 years. My husband has a hernia and bronchial asthma; my daughter needs some dental work done, but the dentist she was going to promptly lost interest when he learned that my husband's firm recently went into bankruptcy.

I have on at least two occasions called a doctor and have been asked if the patient had the money to pay for the call. I took a child, an accident case, to the hospital, and they refused to do anything for the child until I agreed to pay the bill if the child's parents wouldn't.

I know that there are many fine doctors and hospitals, but I have certainly had some unfortunate experiences with some of them.

And then I know people that can't even provide proper housing and food for their children—much less medical care. I know of one case where a child had to leave school because he couldn't learn and he couldn't learn because his undernourished body was diseased and painful. I was of the opinion that he had rheumatic fever, but he never saw a doctor. His mother didn't have the money to take him to a doctor.

There must be many more cases like these, and it is quite conceivable that some of our juvenile delinquents may originate from such uncared-for bodies.

Yes; the picture is wrong somewhere. They say there are too few doctors, doctors' waiting rooms are always crowded; few people can really afford medical attention, and yet I understand that so many doctors are against socialized medicine. They don't want to credit the masses that cannot pay. They do not seem to be concerned about the great numbers of people that cannot pay anything at all and do not get any attention at all, nor about another large group who seek medical attention and pay for it the hard way, by, maybe, doing without other necessities.

I am not a politician. I know very little about the socialized-medicine plans. I want no sort of publicity. I have no ax to grind anywhere. I just want to help those that need medical care and cannot pay for it.

Yours,

——— ———.

STILLWATER, OKLA., *June 21, 1949.*

Senator JAMES E. MURRAY,
Washington, D. C.

DEAR SENATOR: I just finished your article published in the current issue of Look magazine and I must say that it is with much concern that I view Dr. Sensenich's attitude. Either Dr. Sensenich is not aware of the plight of millions of Americans or else there must be a fear of the removal of the God-like pedestal that most doctors stand on instead of their actual services to humanity.

I am employed by a public service co-op and am drawing a salary of $300 per month and I think you will agree with me when I say that this is considerably above the average. Most of my acquaintances average less than this and since my job takes me into seven counties I can truthfully say that I am better off than the average. Yet I cannot provide adequate medical services for a wife and three children ranging from ages 2 to 6. Many of the bare necessities of life have to be closely budgeted in order to provide the minimum medical attention, and the past year my expense for this ran approximately 20 percent of my total salary. Yet I feel like I am lucky for at least I could pay this much as many of my friends are still awaiting the day when they can afford to have their teeth worked on or else have some physical ailment taken care of. They are still waiting and will always wait as long as they haven't the means to do so.

If Dr. Sensenich would like I would be only too glad to take him on a tour to these homes—homes of teachers, preachers, and other public servants who now are public slaves to the AMA.

Yours very truly,

——— ———.

PRINCETON, N. J., *June 14, 1949.*

Hon. JAMES E. MURRAY,
United States Senator, Washington, D. C.

DEAR SENATOR MURRAY: Have just finished reading article Socialized Medicine? appearing in June 21 issue of Look magazine, and while I believe there are honest and sincere differences of opinion on both sides of this dispute I lean very strongly toward your side for the reason that too many people are being denied adequate medical care due to a shortage of physicians and nurses plus the high cost of medical treatment when able to pay for it.

Organized medicine has directed and controlled public health matters in this country for many years and has neglected and failed to provide adequate medical care for a substantial part of our population; and while I do not feel qualified to declare that socialized medicine will be a solution for all public health problems, I do believe that some form of governmental direction will be required to provide adequate medical care for all who need it.

Based upon our factual experience with physicians over the past 10 years, our family has found too many physicians boldly mercenary while lofty specialists require a patient's financial standing before diagnosing and prescribing treatment. In one instance, about 3 years ago, an out-of-town specialist would not agree to visit and examine a patient in our family until we sent him a certified check for $500, and our credit rating is A1. So I can imagine what chance a seriously ill patient would have if he lacked the fee.

I feel certain that a substantial majority of the lay public are in sympathy with and will support any national movement that promises better medical care and treatment than we are now getting. * * *

DUSHORE, PA., *June 13, 1949.*

Hon. JAMES E. MURRAY.
United States Senate, Washington, D. C.

DEAR SENATOR: I have just finished reading an article in Look magazine in which you compared views on national health insurance with Dr. Sensenich of the American Medical Association.

As one who has gone through a struggle for health and existence during the past 30 years, may I add my views to the discussion.

I heartily agree with you that the majority of American people cannot afford the rates which medical authorities charge for treatment and hospital facilities.

I believe the average income of most wage earners is no more than $2,000 per year and with five or six dependents it is plain to see that a family budget, regardless of the care with which it is apportioned, will not permit of unexpected and unforeseen expenditures for medical needs.

It is true that voluntary group hospitalization is a great benefit, but everyone who carries it complains of its severe drain on the budget which makes necessary reductions in other vital needs.

Those forced to live on fixed incomes have no protection at all and most State-aided hospitals have instituted policies which amount to a cold-blooded repudiation of the Hippocratic oath.

There are hundreds of chronically ill persons turned away from hospital doors here in Pennsylvania for no other reason than of inability to pay. Under a smooth cloak of professional paternalism a stealthy elimination of those in lowest-income brackets is being accomplished in our so-called humane fields of endeavor.

It is astonishing how a professional code of ethics can be prostituted to monetary considerations.

It is indeed a sad commentary on the ideals of democratic institutions that in our Pennsylvania hospitals (and no doubt it is true elsewhere) that a stethoscope is placed on the patient's pocketbook before it is placed on his chest. (I am prepared to submit a sworn affidavit to certify to this statement.) * * *

EAST ORANGE, N. J., *April 26, 1949.*

Senator JAMES E. MURRAY,
Washington, D. C.

HONORABLE SIR: I have read President Truman's proposal for medical care for everyone and hope and pray it may become law.

* * * My husband is 60 years of age and has a chronic lung and sinus condition which makes it impossible to work indoors.

* * * In 1948 my husband's gross income was less than $3,000. His cost to do business about $925. My medical expenses were over $1,000. I have been ill for almost 10 years. We are in debt. For doctor, accrued in 1949, so far, about $500. All our savings are gone. Ill health made us lose our home. My husband and I need dental care, but cannot afford it. He needs specialist care for his ailment, but cannot afford it.

* * * We have New Jersey hospitalization, which takes care of 3 weeks' hospitalization—I was in the hospital 3 months. With three patients in a room it costs $12 a day (of course, too much). The hospitalization paid $3.50 a day for 90 days after the first 3 weeks. Why should hospitalization insurance not pay for one's entire hospitalization? The way it is now, thousands never use their insurance, and for security, surely they should pay the whole bill (as is, the security is negligible).

New Jersey has insurance for doctor and surgical bills, but because my husband works on commission or, as they call it, self-employed, we are not entitled to pay for that kind of policy. Is that fair? * * *

FORT WAYNE, IND., *December 6, 1948.*

Hon. Senator MURRAY,
Washington, D. C.

SIR: I take great pleasure to write to you in regard to your social-health program. If this bill goes through, it will be the finest bill that ever helped the poor and middle-class people. I would like to take time and tell you my reason. First, I'm a married man and raised two step-boys. In the year of 1929 my wife was taken sick and had a diagnosis of her case, and it was found that she had a malignant tumor or in other words a scattered tumor. Her specimens were sent to Ohio University and to Indianapolis University. It was sent back, as I said, a malignant tumor, and she was told how many radium and X-ray treatments to take. Well, my wife couldn't make up her mind about taking the treatment, as I had a small income of $16 a week, and the treatments were high. So she got so bad, that is, in 1930, she had to take them and I didn't have the money, only working 3 days a week. I did try to pay as much as I could afford. So she took 10 treatments. But she still had two more to go, but she saw that we could not afford it as it took everything I earned to make our living. So she didn't take any more. It was only a matter of 2 to 3 months the doctor attached my wages because I didn't have the money as I was working for low wages. So a program like yours would have brightened our future and worries. And still I work 40 hours a week and my wife needs some more treatments, but we can't see our way, as our living is high, and rent, so we can't save any money for some more of her treatments. I had an operation for a fistula. My firm has a group insurance and this insurance allowed me $25 on the operation and I had to make the difference of $75—and I'm not well yet. So you can see why I like your social health program. Just think how many other persons like me think what a good program it is. It would be a great relief for the laboring people. You could go to a hospital and have your operation done and you would have no worry. Our bill would be paid through our social health program. That would be quite a relief for everybody. We have millions of people who need operations of some kind but just can't see their way to have. They have no security.

Thanking you,

——— ———.

LITTLE ROCK, ARK., *December 6, 1948.*

Senator MURRAY,
Washington, D. C.

DEAR SENATOR MURRAY: I was happy to read this morning of your predictions in the press that your national health program would be enacted by the next Congress. No one knows the value of such legislation until circumstances place a person in a position to appreciate it.

I have paid several hundred dollars in income taxes in recent years and a considerable amount to doctors. Recently, my own wife was taken ill and the very doctor whom we both had paid considerable money in the past and in full showed slight interest when we suggested that maybe he could carry a portion of our medical bills. Certainly, I hold no resentment against him; that is his business. He perhaps reasoned, and correctly, that I could dig it up from my friends. So my wife, rather than see me ask for charity from my friends suffered for 5 weeks and finally recovered without a doctor. And yet I am a taxpayer, pay my Federal income tax each year, keep a record for inspection, and frequently contribute money to charitable organizations. And still many will insist that anybody can procure medical attention and medicine. Many of us who have been in close places as I have outlined know that statement is not literally true * * *.

JANUARY 10, 1949.

DEAR SIR: Let's have a healthier America, with health insurance.

Your approval of health insurance is a wonderful thing. I wonder how many Americans realize it. I received the benefits of this insurance over 30 years ago in England. I never gave doctors' bills a thought, or medicine, until I came to America. You also get your prescriptions filled by doctors at low cost. What a difference in America. I have heard it said drug stores make more profits on prescriptions than anything in their stores. I paid a few cents every week but when I was sick I went to my doctor of my own choice or if too sick he comes to the house. I have lived in America over 25 years; I have met a large number of people who are sick but unable to afford medical care because of lack of money to pay the doctor * * *.

CORPUS CHRISTI, TEX., *April 17, 1949.*

Senator MURRAY of Montana,
United States Senate, Washington, D. C.

DEAR SENATOR: I see where you are a backer of the President's health program.

I wish to tell you we do in the worse way need something like socialized medicine.

Take myself, like many others. We need a doctor at times, and the most of them have got to know if the money is there before they came. In Oklahoma City in 1936 my brother-in-law was dying of flu. We took him to a hospital. They wanted to know if we had the money to leave him there. We had to have the money before a doctor would look at him and they fooled around until he died for the want of care. He was a Mason. I wasn't there, as I was employed in the National Park Service and had to come 200 miles. Mother had to get a check from another Mason before he got any service, which was too late.

Since then I have got my back hurt. I cannot work at my trade which was a stone mason, and my wages were $2.50 per hour. Now I have to do yard work or light work which brings me about $35 a week. I must pay house rent, $50, and mother is old and almost blind. I sent for a doctor; he came to see mother and took a small bottle of urine, which he himself looked at. Trip to the house was $5, testing urine $2. He phoned a drug store, and three small bottles were sent to the house, $9.10. I said, "Hell, no; take it back." I called the doctor; he said it's a mistake. So the medicine came back, $6, and when the boy came he said the doctor came over and knocked his part off. The same medicine in another drug store six blocks away cost $2.70. Now, Senator, that is why I say, something should be done.

The Government could have a place; when the doctor gives you a prescription a person could take it to the Federal pharmacy.

Poor people have gotten so that if they don't have the cash, no doctor. No one like myself with wages around $140 a month, house rent $50, groceries, $20 a week, and in March alone two trips by the doctor to the house, seven blocks, $14; medicine for mother and myself, $40.85.

If you fellows don't do something about these doctors that rake off in drug stores and the price of medicine, folks like me are going to die for the want of a doctor and medicine. I would sure like to tell Congress the way many doctors operate and let many die for the want of medicine. There are a few that will call on you whether you have a penny or not; so I say, for God's sake do something. I can get many signers to support you.

Yours very truly,

[From the Wall Street Journal, New York, N. Y., March 7, 1949]

DOCTORS' AILMENT—WAITING ROOM CROWDS THIN OUT; PATIENTS ASK LONGER TO PAY—HOSPITALS REPORT CLINICS ARE JAMMED, BUT MANY PRIVATE ROOMS ARE NOW EMPTY

PILLS INSTEAD OF X-RAYS

Doctors across the Nation have a new patient to worry about—their own ailing practice.

"I've begun to wonder lately whether they're picketing my office, the way business is falling off," comments a prominent San Francisco general practitioner.

Not all physicians report a really sharp decline, but a New York City ear, nose, and throat specialist reports: "People are beginning to wait until they have something really wrong with them before they go to the doctor. The desire to keep healthy seems to be losing ground to the desire to keep expenses down."

WHAT THEY SAY

Scores of medicos interviewed by Wall Street Journal reporters in 12 key cities tell the same story: Fewer people in their offices, slower payment of bills, patients deferring check-ups and treatment of minor ailments and less requests for X-rays and other special services.

Many hospitals note a decided pick-up in free medical clinic traffic and increased preference for ward and semiprivate accommodations instead of private rooms.

Doctors are traditionally untalkative when it comes to their own financial status, but few fail to report a falling-off in the number of patients within the past few months. The decline has hit both general practitioner and specialist, diagnostician, and surgeon.

A leading Boston pediatrician, who has written many articles for baby food trade publications, says until a few months ago he was handling more cases "than one man should treat." Today his calls are considerably fewer. A Detroit physician who runs a rehabilitation clinic with a middle-income group clientele finds his visitors have declined about 25 percent since last December.

A middle-aged general practitioner in Los Angeles was swamped with patients all during the war and up until 6 months ago. Since then, he reports, his patients have dropped about 25 percent in number. A physician on Chicago's West Side doesn't know the exact number of callers he's getting today but he does know this: "I'm getting out of my office at 9:30 or 10 in the evening now. Not too long ago I had to stay until 10:30 or 11."

THEY'RE SLOW TO PAY

Almost without exception doctors find collecting bills a tougher proposition. A 40-year old member of a Portland, Oreg., group of eye, ear, and throat specialists declares: "Collections were the poorest last month since I joined the group. I've been telling my patients to pay hospitals first; now I'm beginning to wonder if we shouldn't get some of it first."

A general practitioner in Newton, a Boston suburb, says about one-fifteenth of his patients are now paying cash as against a seventh until recently. An obstetrician in the same city comments that patients who formerly would pay a $200 fee in cash are now settling at the rate of $50 a month.

The trend to ask for credit and a longer period in which to settle accounts began 3 or 4 months ago. "In the past 90 days," says the business manager of a clinic in a Dallas suburb, "there has been a noticeable increase in the number of our patients requesting some form of time payment."

A well-known Cleveland surgeon, noting a current lull in both operations and collections, attributes it to industrial lay-offs and the income-tax-paying season. A less charitable view is expressed by a Philadelphia radiologist: A certain class of people, he asserts, have always paid medical bills promptly and they still do; others are putting on an "act" with hard-luck stories.

BUDGET CONSCIOUS

The average time for paying doctors bills in Detroit is now 90 days compared to 30 days during the war and early postwar period. A heart specialist in downtown Pittsburgh is not upset by the longer payment period: "I have a lot of good, honest people who are paying so much a month whereas in 1946 and 1947 they would have paid the whole amount at once. These people are in good circumstances and are simply watching their budgets.

But a doctor in Los Angeles has noticed more than increased requests for credit. "Plenty don't pay their debts at all now," he charges.

Pittsburgh medicos say their patients are beginning to question bills and to demand break-downs into charges for various items. There's more and more of the "gimme" spirit in the air, observes a general practitioner in that city. "Some people," he comments, "seem to think socialized medicine is already here. They expect more attention for less money. Many want to go through the cancer clinic, even though they have no trace of cancer symptoms, for the free X-ray and blood count."

Physicians report more and more people are putting off treatment for minor ailments as well as asking for less elaborate and costly services. One Boston hospital's backlog of 200 surgical and neurosurgical cases has been wiped out; officials attribute that situation to a tendency to defer "elective" operations—the kind that aren't imperative.

HE TAKES THE PILL

"When a patient gets a choice between a pill and an X-ray treatment nowadays," says a New York ear, nose, and throat specialist, "he usually takes the pill." This physician adds that some patients tend to "peter out" on an extended course of treatments: others try to get as much information as possible on one call to keep the number of visits down.

Like most doctors, a New York general practitioner uses a sliding scale of fees, adjusted to the financial status of the patient. He notices a piling up of cases at the bottom end of the scale. "More people whom I'd size up as being able to pay a certain fee are saying, 'I can't pay that, doctor,' so I have to shift them lower down in the scale." In practice for over 29 years, he has also been hard hit by a one-third drop in the number of his patients since the 1st of November.

Statistical comparisons of doctors' fees mean little because of the patient-income yardstick. But a Washington, D. C., surgeon's policy is fairly typical: "If a man has an income of $10,000 a year, I charge $150 to take his appendix out. If he makes $5,000, then the bill is $75."

Many specialists see budget-tightening behind a decline in thier business during the past 3 or 4 months. Take the case of a consulting anesthetician in a large New York hospital: Most of his patients come to him on the recommendation of another physician. Now, he says, patients are beginning to question whether a specialist's services are really necessary. "They want to get as much done as possible by their general practitioner and they come to me, a specialist, only when they have to. When they do come, they are likely to balk at the high bill."

ANY CURE?

Medical men have little to suggest in the way of a "cure" for the hardening of economic arteries. The usual recourses of a sagging business—new products, sales promotion—are hardly applicable in their case. Advertising is, of course, forbidden by the ethics of the profession. But at least one New Yorker recently received an indirect sales talk from his family physician. This little note from Dr. X turned up in his mail: "It has been more than 6 months since you and your family has a physical check up. You are now due for another. (Signed) Dr. X. Office hours, 10 a. m. to 5 p. m., Monday through Friday, and by appointment."

Some statistics from Chicago reveal a marked increase in free or low-cost clinic treatments. Welfare cases at that city's Presbyterian Hospital jumped 40.9 percent during January and February over the same 2 months last year (the city gives the hospital so much per welfare visit). Free or charity visits at Presbyterian rose 11.6 percent during that period over the 1948 level. The Fantus Out-patient Clinic of the Chicago Cook County Hospital handled 14 percent more charity cases in January and February than in those months last year.

The assistant superintendent of a New York hospital reports a considerable increase in dispensary patients since the first of the year. These patients, who supposedly can't afford a private doctor, are charged $1 a visit with an added fee for extra services such as X-rays and laboratory tests. This dispensary had 5,672 patient-days (one patient, staying 1 day) in January, a rise of about 10 percent over last January.

In the 28 municipal hospitals and "homes" in New York, where patients are charged only what they are able to pay and where they get free service if they can't pay at all, the population increased from 18,740 on January 1, 1948, to 21,285 on the 1st of this month.

LESS PRIVACY, LESS COST

The director of a private New York hospital has noticed a definite shift from high-priced private rooms to semiprivate and ward accommodations. Three months ago, this hospital had a substantial waiting-list for private rooms; today, they're only 83 percent occupied while semiprivate quarters are 96 percent filled and wards are 90 percent taken.

Hospital officials in all sections of the country credit the Blue Cross hospitalization plan and other insurance plans with swelling the demand for semiprivate rooms. In New York, for instance the Blue Cross pays the rent and board cost for 21 days in a semiprivate room plus half of the fees on various hospital services during the following 180 days. The plan pays $6 a day on private accommodation charges which, in most hospitals, is less than half the bed and board cost.

Prepaid hospital insurance coverage has been spreading rapidly in recent years. Duane Kirk, assistant manager of Portland's Industrial Hospital Association, reports a "majority of the working class covered" in that city. In the metropolitan New York area alone Blue Cross membership rose from 2,788,987 on December 31, 1946, to 3,656,321 by the first of last month.

[From the Progressive, May 1949]

THE ANATOMY OF A LOBBY

(By Nathan Robertson [1])

Until recently the railroads and the insurance companies were generally regarded to have the slickest and best organized lobbies in Washington. Both were powerful and effective because they could operate behind the scenes, without too much open activity in Washington. By turning on their propaganda faucets, they could pour into Washington a tremendous amount of pressure from back home—pressure which didn't seem to be inspired by any central directing propaganda agency.

But the American Medical Association now has them both beaten. It has taken their idea and improved upon it. The backbone of the AMA lobby is the 140,000 member doctors scattered throughout the country, most of whom have the highest standing in their communities, are in close touch with important people, and sooner or later are in touch with almost everybody.

This army of physicians has now been tightly organized into an efficient lobby by the AMA under the skilled direction of past masters in the game, the public relations firm of Whitaker & Baxter. It is armed with several million dollars contributed by the doctors themselves under the AMA's assessment of $25 a head.

The firm of Whitaker & Baxter, which has handled many such lobbying campaigns in the past against a whole series of progressive measures in California, has set up a general in every State who works through the State medical society and the 3,000 county societies organized throughout the country to keep the drive rolling. The propaganda themes are developed by Whitaker & Baxter and passed down to the doctors in every community through this distribution machine. The doctors feed it to their patients, to their local organizations and papers, and to their Congressmen.

Like that of the skillfully planned railroad and insurance lobbies, the aim of the AMA campaign is to make the resulting pressure on Congress seem like a grass roots revolt, without directed inspiration of any kind. This is done by getting other people to front for the organized profession in applying pressure on the Congressmen. And at the heart of this program is the "scare" technique.

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[1] Nathan Robertson, long a top-flight Washington correspondent, has been doing special research recently for the Committee on the Nation's Health. He served for many years as chief of the Associated Press' Senate staff and more recently as a Washington correspondent for PM. He has won the Haywood Broun journalistic award for the excellence of his Washington coverage.

A doctor, talking to a patient, may quietly slip into his conversation a warning that if "socialized medicine" is adopted by the Government, he is going to stop practicing medicine. The patient, who has depended upon that doctor for years, is quickly alarmed and writes his Congressman an angry letter about "socialized medicine," although in most cases neither he nor the doctor could even give a rough outline of how the proposed national health insurance program would work.

Another doctor, who is one of the most popular members of the local Kiwanis Club, or chamber of commerce, arranges for a prominent speaker to tell that group how "socialized medicine" would lower the standards of medical care, create a tremendous bureaucracy, and perhaps wreck the Treasury. The alarmed club members rush through a resolution opposing socialized medicine and send it off to Washington.

Usually this club or group has never entertained the idea of hearing a speaker present on the other side, to learn whether the "facts" it has been given are authentic. The speaker has been provided by Dr. So-and-So, who is one of the finest guys in the world, and no one doubts that he is an authority on the subject.

If you want to know how little most doctors know about the terms of the bill, write to the Committee for the Nation's Health, Kellogg Building, Washington, D. C., and get material describing the legislation. Then try it out on your doctor. Agree with him that you are against "socialized medicine" and then start discussing a plan that you think he might like. Go through the provisions of the proposed national health insurance program (outlined in the February issue of the Progressive by Senator James E. Murray of Montana) and see if he doesn't think most of them are pretty good. You will be surprised how many thoughtful doctors will go for the program without realizing it is what they have just been damning as "socialized medicine."

But this has nothing to do with the influence of doctors in their communities. They have more influence on this subject than anyone else in the community. Even in a debate, the public is likely to take the side of the doctor regardless of the merits of the argument—unless there is a doctor opposing him. And, of course, there are tragically few doctors who will stick their necks out unnecessarily to buck the AMA on this issue, even if they have grave misgivings about the position the powerful AMA has taken. A doctor who thinks maybe health insurance would be a good idea keeps quiet because he knows most of his colleagues feel otherwise and maybe begin to shun him if he talks too much.

I know a young, forward-looking doctor, who has set up practice in a new community as a specialist. He is dependent for business entirely on the good will of his fellow practitioners, who must send him his patients. He has just joined the local medical society. One of the first communications he received from the society was his bill for the $25 AMA assessment. He didn't want to pay it, but he did, with apologies to me because he knew how strongly I felt on the subject. But he explained, and I agreed with him, that he didn't have a chance in that community unless he paid the assessment.

Or take the case of a more prominent doctor—one who was well enough established to speak out. He was a professor of pediatrics at a State university. Early this year, this doctor joined with a group of 130 prominent doctors all over the country, headed by a noted physician at Johns Hopkins, in a public protest to the American Medical Association over the collection of the $3,500,000 lobby fund. They urged that the money be used by the AMA to work out a better medical system, rather than be spent on lobbying against the President's health program.

The AMA did not like this one bit. It cracked back at the group publicly in the sharpest terms. But it did its dirtiest work privately. The pediatrician, for instance, had been invited by a professor at the University of Arkansas to give a postgraduate lecture to practicing physicians at Little Rock on the subject of the feeding and immunization of babies. As a pediatrician, he was an expert in the field.

A few days later after the public protest signed by the doctor and others was made public, the announcement of his forthcoming lecture was published in Arkansas. One of the leaders of the Arkansas Medical Society is a member of the AMA committee handling the $3,500,000 propaganda campaign against the President's health program. Within a few days, the pediatrician got this letter, signed by the State health officer of Arkansas:

"DEAR DR. ———: This letter is being written to you as a result of a special request made by the Arkansas State Medical Society and the Pulaski County

Medical Society, with reference to your appointment as a special consultant in pediatrics for the Arkansas State Board of Health for the postgraduate pediatrics course to be conducted at the University of Arkansas School of Medicine, Little Rock, during the period March 10 to 12, inclusive, 1949.

"The Arkansas State Medical Society and the Pulaski County Medical Society have been advised through authoritative sources that you were one of the 136 signers of certain papers and documents severely criticizing the American Medical Association. Through this action on your part, the Arkansas State Medical Society and the Pulaski County Medical Society request that you not appear on the postgraduate pediatric course to be conducted on the above-referred-to dates.

"This department sincerely regrets that this most embarrassing situation has arisen and further regrets that it is necessary to cancel your appointment as special consultant for the Arkansas State Board of Health."

That is a profoundly disheartening commentary on the way the AMA is conducting its political campaign. That professor was saying, in effect, that because he exercised his right of free speech to protest an action by the AMA, he was barred from giving the public and the profession the benefit of his professional training and experience on a scientific subject.

This doctor did not even come out for the President's program. All he and his associates did in their protest was to object to the fact that the AMA, a professional and scientific society, was getting mixed up in politics—particularly in emphasizing a negative position without offering a constructive alternative. What would have happened to the doctor if he had publicly espoused the President's health program?

II

The AMA has sent a "mission" to Great Britain to study the medical care program in operation there. Undoubtedly it will return with an unfavorable report because AMA propaganda about the failure of the British program has been back firing. Too many independent journalists have reported just the opposite. The AMA is determined to attempt to repair the damage with its own special report.

The AMA will have difficulty, however, answering this report from the official British medical journal called Lancet:

"Both doctor and patient are pleased with their new and easier relationship. Before July 5 (when the plan went into effect) doctors were unhappily familiar with the words of the less well-to-do uninsured patient, 'I think I'll get along all right now, doctor,' meaning that the family wished to be spared further fees. This is ended. Patients are also gratified to observe that the new service is truly comprehenhive * * * Complaints are few."

Even tougher for the AMA to overcome will be this final observation by Lancet, in connection with the AMA's claim that the program was creating a Nation of hypochondriacs: "Practitioners, whether in town or country, agree that they are making hardly any more, and sometimes fewer, visits than they usually do at this time of year. Every account agrees that frivolous complaints are no more common than before."

III

Now the means by which the AMA raises its funds is not so important as the uses to which the money is put. The whole story on that will not be known until there is a Senate lobby investigation. Much of the money is being used for distributing propaganda. Much is being used to train community speakers to flood organizations and newspapers with speeches against the President's legislation. Much probably will be used in advertising to soften up further the already overwhelmingly sympathetic press.

The firm of Whitaker & Baxter got its present assignment as a result of its success in beating similar legislation on a State basis in California. The firm was employed by the State medical society which financed the battle on a comparable assessment plan.

One of the most significant disclosures on the tactics of Whitaker & Baxter in defeating Gov. Earl Warren's medical program in California came from the doctors themselves.

Boasting of how his State medical association had crushed a health-insurance program sponsored by Republican Governor Warren, a spokesman for the organization recently told a national conference of medical society editors this story:

"We went to the California Newspaper Publishers' Association and said: 'Gentlemen, we are going to spend a lot of money with the newspapers. We are going to advertise in every one of the 700 papers in the State.'

"Each of the 700 newspapers received a minimum of 100 column-inches of advertising in a period of 12 months. We found that the response from editors in publicity has been far beyond anything we expected when we started the campaign."

Whitaker & Baxter will have $3,500,000 to play around with for the AMA's national campaign. So don't be surprised if your paper blossoms out one of these bright spring days with a great blast against "socialized medicine." The AMA lobby has mastered the technique of letting others front for it.

[From the New York Herald Tribune, April 15, 1949]

AMA Censure of Doctor Over Fund Charged—Senator Morse Says Foe of Assessment Was Forced Off Univerity Program

(By Bert Andrews)

Washington, April 14.—Senator Wayne Morse, Republican, of Oregon, told the Senate today that two "satellites" of the American Medical Association forced a doctor off a university program because he signed a protest against the association's "slush fund" to fight President Truman's health-insurance program.

Noting that the physician was to have spoken on "infant feeding and immunization" Senator Morse declared that the action of the "satellites" showed that the AMA was more interested in defeating the President's program than in "saving the lives of babies who die unnecessarily."

He also implied he would seek a congressional investigation of the AMA's actions in the case.

Senator Morse withheld the physician's name "lest disclosure get him into more trouble." He named Dr. T. T. Ross, State health officer in Arkansas, as the man who withdrew the invitation to the doctor to speak at a postgraduate pediatrics course at the University of Arkansas School of Medicine in Little Rock. He made public Dr. Ross's letter to the doctor.

REPORT CONFIRMED

Dr. Ross, reached by telephone, said the basic facts as given by Senator Morse were correct.

"We just didn't think that the doctor would be very well received under the circumstances," he said.

"Did it have something to do with his opposition to the AMA plan?" he was asked.

"Well, I think there was something there, yes," he said. "Not necessarily the AMA, but why have someone as a speaker who was so strongly in favor of the other kind of program?"

Dr. Ross said at first that he thought the doctor involved was from New York State.

He was told that information obtained in Washington—not from Senator Morse—indicated that the doctor was from Louisiana. He was told that the name given was "Wegman." He said:

"Maybe that's right. I am at home. I don't have my records with me. I was under the impression that he was from New York."

DOCTOR'S NAME REVEALED

Further investigation developed that the doctor concerned was Dr. Myron E. Wegman, professor of pediatrics at the Louisiana State University School of Medicine at New Orleans.

Reached by telephone at Tuskegee, Ala., tonight, Dr. Wegman confirmed that he had received the letter and said he was not concerned over any effect that use of his name might have on him personally. He also remarked that the Louisiana Medical Society had adopted a resolution censuring the signers of the protest against the AMA "slush fund."

Dr. Wegman was one of 136 physicians who signed a round-robin letter protesting an AMA assessment on each member—if the money was to be used for "propaganda and lobbying," rather than to develop a comprehensive national health plan. The letter was sponsored by Dr. Edwards A. Park, of Johns Hopkins University, a pediatrician of international eminence.

Dr. Park was reached later tonight by telephone at his home in a suburb of Baltimore. He declined to comment on the projection of the issue into the Senate by Mr. Morse, but described Dr. Wegman as a "very able pediatrician" and the "finest kind of a man."

"I don't see," Dr. Park said, "that his value as a teacher is reduced in any respect because he has views which differ from those of the AMA."

SEEK CONSTRUCTIVE PROGRAM

Dr. Park pointed out that the protesters who signed the round-robin letter are opposed to compulsory national health insurance and that their action was motivated by a desire to have the AMA adopt a more constructive program. Observing that the barring of Dr. Wegman from lecturing at the University of Arkansas smacked of a "suppression of free speech," Dr. Park said:

"I don't think the trustees of the AMA will approve of the action of Dr. Ross."

The text of Dr. Ross' letter to Dr. Wegman said it was written at the "special request" of the Arkansas State Medical Society and the Pulaski County Medical Society. It referred to the invitation that had gone to Dr. Wegman to speak during the post graduate course on March 10, 11, and 12. It added:

"The Arkansas State Medical Society and the Pulaski County Medical Society have been advised through authoritative sources that you were one of the 136 signers of certain papers and documents severely criticizing the American Medical Association."

CANCELS APPOINTMENT

"Through this action on your part the Arkansas State Medical Society and the Pulaski County Medical Society request that you not appear on the postgraduate pediatrics course to be conducted on the above-referred-to date. This department sincerely regrets that this most embarrassing situation has arisen and further regrets that it is necessary to cancel your appointment as special consultant for the Arkansas State Board of Health."

Senator Morse charged in the Senate that the case showed that the AMA was "blackmailing," "censoring" and "punishing" doctors who oppose its "slush fund."

"While I am not an advocate of national health insurance myself, I am shocked at this callous disregard of basic rights by the American Medical Association and its satellites," he said. "I am informed that this is not an isolated case—that the AMA has brought pressure of one kind or another against many doctors in many parts of the country to prevent them from speaking their minds on the subject of what is best for the American people in the way of a health program.

"I believe it is time for us to investigate this situation and determine who is bringing this kind of pressure on doctors and how they are exerting it. Short of such an investigation I do not see how Senators can tell what the public sentiment on this issue may be. Certainly a campaign of propaganda and mail, paid for by millions of dollars, is no evidence of public sentiment."

[From Labor, June 4, 1949]

Reform or Get Health Insurance, Millionaire's Wife Tells Doctors

One of the worst indictments of the American Medical Association—the Doctors Trust—came this week from the wife of a multimillionaire banker and newspaper owner, Mrs. Eugene Meyer. Her husband owns the Washington Post and made his "pile" in Wall Street.

The other day she spoke at a meeting of the District of Columbia Medical Society. She had been invited because she was known to be a vigorous opponent of Federal health insurance legislation, but what she said proved to be a bombshell to the listening physicians.

Bluntly, she warned that if health insurance does become law, the AMA will have only itself to blame because it has resisted every move to bring adequate medical care within reach of the people generally.

Mrs. Meyer predicted that Congress won't enact the legislation this year, thus giving organized medicine "a breathing spell" to mend its ways.

"We will eventually accept compulsory health insurance in the United States," she declared, "unless medical leadership works out a new, constructive, and truly democratic plan for cooperative endeavor with local, State, and Federal Governments for the dissemination of medical care and health protection."

On the scientific side, she said, medicine has made tremendous advances in the past few years, but the gains have not been made available to the people "on a comprehensive scale."

"That's largely because the American Medical Association has spent its energies fighting every attempt at cooperative action made by the people themselves," she charged.

[From the American Druggist, March 1949]

(Submitted by the Committee for the Nation's Health, Washington, D. C.)

OPINION LEADERS STRONGLY FAVOR TRUMAN HEALTH PLAN

(By Maurice Mermey)

SIXTY-SEVEN PERCENT OF EXECUTIVES OF CITIZEN GROUPS, REPRESENTING 40,000,000 PEOPLE, FAVOR PLAN—QUESTIONNAIRE WAS SIMILAR TO THAT SENT TO PHARMACISTS BY AMERICAN DRUGGIST

As of today, national health insurance is regarded with favor by a majority of citizen organization leaders in the United States. Characterized as "opinion factories," because they are an effective force in molding opinion and influencing action on public issues, these organizations comprise thousands of National, State, regional, and local groups. They have a combined membership of approximately 100,000,000; and, even after eliminating duplicate memberships, their rolls include between 30,000,000 and 40,000,000 individual citizens.

In order to learn what these leaders know and think of National Health Insurance, American Druggist turned for cooperation to Resolved, a monthly newsletter of the citizen organization field published by Baldwin & Mermey. The 1,500 presidents and program chairmen of citizen organizations on the Resolved mailing list were sent precisely the same questionnaire which American Druggist previously distributed to retail druggists. Responses were received from 360, or 24 percent, of these leaders. Here are the highlight results of the citizen organization survey:

Of those leaders who expressed an opinion, two out of three favor national health insurance, while one out of three either favors the present system or considers the Truman proposal dangerous.

Of those who responded, one out of eight expressed no opinion.

Of the 242, or 79 percent, who answered question 1 correctly: 166, or 69 percent, favor the Truman proposal; 68, or 28 percent, favor the present system; 8, or 3 percent, take other positions.

Of the 25, or 8 percent, who answered question 1 incorrectly: 13, or 52 percent, favor the Truman proposal; 10, or 40 percent, favor the present system: 2, or 8 percent, take other positions.

Of the 41, or 13 percent, who didn't know enough about national health insurance: 3, or 7 percent, favor the Truman proposal; 5, or 12 percent, favor the present system; 33, or 81 percent, have no opinion.

Of those who responded, four out of five gave the correct answer as to how national health insurance would operate.

Of those who gave the correct answer, seven out of ten favor national health insurance.

Of the organizations with which the 1,500 leaders are affiliated, 650 are national; 475 State, 325 local, and 50 are regional groups. As compared with the fact that 79 percent of the valid responses gave the correct answer as to how the program would operate, 67 percent of the leaders polled should have been familiar with the subject because they belong to organizations which deal with social, economic or health and welfare issues or have general programs of which National Health Insurance should be a part. On the other hand, 500 organizations, or 33 percent, deal exclusively with international, interracial and similar issues, and not with matters related to national health insurance.

The significance of these organizations' support for or opposition to the Truman program lies in the fact that they include such groups as the National Board of YWCA's, National Council of YMCA's, National Federation of Business and Professional Women's Clubs, American Association of University Women, Congress of Parents and Teachers, League of Women Voters of the United States, National Education Association, Federal Council of Churches of Christ in America, American Legion, American Jewish Congress, National Catholic Welfare Conference, and National Association of Consumers. State, local, and regional groups are, in large part, branches of these and other national groups; those which are not concerned primarily with local issues.

Encouragement will be found by those advocating the Truman program in the fact that 182 leaders, or 67 percent of those who took a position, favored national health insurance. This is, indeed, a significant figure, for it foreshadows the possibility of broad grass roots support for the Truman program. Advocates will also be heartened by the fact that leaders with knowledge of the program favor it more than do other leaders, as witness the statistics shown on page 90.

Opponents of the Truman program may also find rays of light in the survey's findings. A pattern of strong citizen organization support for social issues is reflected in our Catalog of Attitudes which lists the positions these groups have taken on 200 national issues. In respect of national health insurance, the catalog lists support by 37 groups (excluding farm, labor, business, and professional) and opposition by only four. The survey, on the other hand, shows a less decisive pattern, with one leader opposing the Truman program for every two favoring it. Also, of 52 questionnaire replies which were invalidated (incomplete, more than one answer per question, etc.) 30 leaders favor the present system and only two favor the Truman proposal. Let it be understood, however, that these are merely rays; for, by a very substantial majority, citizen organization leaders beam on the Truman program.

Significant of the interest in the subject and in the questionnaire is the fact that comments accompanied 124, or 34 percent of the replies. Twenty-four leaders commented unfavorably on the questionnaire, some criticizing the word "compulsory," others criticizing what they regarded as inadequacy of alternatives offered in both questions, still others questioning the survey itself as being premature. Another 25 commented unfavorably on the socialized medicine aspects of the national health insurance proposal, while 28 commented unfavorably on the campaign of the American Medical Association or of organized medicine in general. Of this latter group, 12 favor the Truman proposal and six favor the present system.

The opinions which citizen organization leaders express respecting national health insurance, or any other public issue, does not necessarily coincide with the positions which may be taken by their groups. On the other hand, our experience in this field indicates that views and positions will coincide in the overwhelming majority of cases. Accordingly, advocates of the Truman program can be satisfied with their score among citizen organizations, while opponents have much work and soul-searching ahead as regard this large and important area of public interest.

[Paper read before the National Consumers League meeting in Cleveland, Ohio, June 14, 1949]

Has Britain Shown That Health Insurance Can Work?

(By John G. Hill, Director of Research, Health, and Welfare Council of Philadelphia, Pa.)

It is now almost a full year since the British National Health Service came into operation in England, Scotland, and Wales. No single act of the Labor Government since it came into power in 1945 has aroused as widespread interest, provoked as much criticism, or provided as many conflicting stories on this side of the Atlantic as that one measure. There is scarcely a discussion these days of the proposal for Government health insurance here in the United States in which at least part of the argument does not hinge on what is, or is supposed to be, happening in Great Britain. If for no other reason than to be able to follow intelligently the current debates on proposals here, it is necessary to know something about the British National Health Service.

It comes as a minor shock to some people to learn that the Labor Government cannot be entirely blamed or credited—depending on one's point of view—with the National Health Service. Government planning for a comprehensive medical-care program really began back in 1941 under Churchill as part of his Government's consideration of postwar reconstruction problems, but the beginnings of the story really go back much farther.

For 36 years prior to inauguration of the National Health Service, Great Britain had had a national health-insurance program which, as its name implies, was based entirely on the social-insurance concept. At the time it was terminated last year, it covered only manual and white-collar workers earning £420 ($1,680) per year or less. Dependents and children of insured persons were not covered. Medical benefits were restricted, for the most part, to general practitioners' services and did not include hospital care or specialists' services. Some twenty-odd million people—roughly one-half the population—were covered and about 84 percent of the doctors in the country were treating patients under this scheme in addition to their private practices. Doctors were paid on a capitation basis, and the cost of the program was met by specified contributions from employees, employers, and the Government.

There were also a variety of other provisions for medical care. For hospital and specialists' services there were voluntary hospitals, municipal hospitals, and public-assistance institutions and special services for the treatment of tuberculosis and venereal diseases, for maternity and child care, and, mainly through voluntary societies, for home nursing care. For those who could not pay, the local health authorities had responsibility for seeing to it that services were made available.

It is of interest to note that for many years Britain had also had voluntary hospital-insurance schemes, roughly analogous to our Blue Cross. In his report on Social Insurance and Allied Services in 1942, Beveridge mentioned an estimate that these voluntary hospital-insurance schemes covered about 25 percent of the population and yielded about £6,500,000 ($26,000,000) annually to the voluntary hospitals.

Despite this array of public semipublic, and voluntary services, there were numerous criticisms. Gaps in the programs, lack of coordination, and the fact that all too frequently medical care was distributed according to economic status rather than medical need, were considered the major defects. Surprisingly to us here in the United States, the organized British medical profession played a prominent part in making this type of criticism and was a leading proponent of corrective measures.

When the National Health Insurance Act was passed in 1911, the British medical profession was vigorously opposed to it. Gradually however, its attitude softened and by 1930 the British Medical Association urged the Government to extend the coverage of the health-insurance program to include the dependents of insured workers, a recommendation which the association repeated in 1938. In 1940, a Medical Planning Commission was jointly established by the British Medical Association and other British medical organizations. Early in 1942, it recommended that a comprehensive medical-care program be made available to everyone in the population. A few months later came the famous Beveridge report in which a comprehensive medical-care program was viewed as one of three "basic assumptions" on which the social-security system which the report recommended must be based. In other words, what Lord Beveridge said was that it would be impossible to create a satisfactory social-security program for the country without such a health service. This was accepted by the Churchill government and by the medical groups, and in 1944 the Churchill government issued a white paper setting forth the method by which it intended to implement that recommendation. This white paper stated as a basic principle that medical care "should be put on a new footing and be made available to everybody as a publicly sponsored service." To this, the British Medical Association pledged its support.

The Churchill government, however, did not remain in power long enough to enact legislation. That was left to the Labor Party and the legislation that was finally adopted differed in several respects from the coalition government's proposals. But the basic principle—that medical care, like education, should be available as a publicly sponsored service to everybody in the population—remained the same and was accepted by all political parties, the British medical profession and the general public.

It should be pointed out that the dispute which arose between the British Medical Association and the Minister of Health early in 1948 and was so widely publicized in the American press did not involve this principle. Rather it dealt with some of the administrative arrangements under which the new service was to be operated. There were four major points of disagreement:

1. The method of compensating the general practictioners: The British Medical Association objected to the payment to all general practitioners of a basic salary along with the capitation fees on the grounds that a basic salary would

ultimately lead to a full-salary service which they strenuously opposed. The conflict was finally resolved by an arrangement under which only those general practitioners would receive the basic salary who requested it and could justify receiving it. Also, the Minister agreed that the method of payment would not be changed to a salary method without review by Parliament.

2. The administrative controls over the location of new practices in the public service: The medical profession objected to the prohibition against a doctor's moving into or establishing a new public practice in a locality designated as "overdoctored." The control remains but is to be reviewed after the act has been in operation for 2 years. It should be noted that this control does not apply to private practice.

3. The prohibition against the sale of public practices: The sale and purchases of medical practices was almost universal in Britain, and the Government proposed paying the doctors for the loss of their right to sell public practices in the new service. The doctors feared they would not receive as much for their practices as normally, and also that ending the sale of practices would interfere with freedom to choose their partners and assistants. Assurance was given of freedom to choose partners and assistants, but the sale of public practices is still prohibited. Sale and purchase of private practices is not affected by the new act.

4. The right of a practitioner dismissed from the National Health Service to ultimate appeal to the civil courts: Under the act, final appeal is to be to the Minister of Health and no concession was made on that point.

It is clear from this brief outline of the background of the British National Health Service that the creation of a comprehensive medical program as a publicly sponsored service open to everyone who wished to use it was an undertaking not solely due to the Labor Party but had the backing of the entire electorate as well as the medical profession itself. Regardless of what political party had come into power in 1945, there would have been a National Health Service which, while it would have differed in many respects from the present program, would nevertheless have had the same objective. A publicly sponsored service was the only plan considered likely to solve the medical-care problem of the Nation; it was a plan evolved after long years of vainly trying to cope with rising medical costs and inadequate distribution of medical care by means of voluntary and compulsory insurance programs covering limited segments of the population, and numerous other public, semipublic, and voluntary schemes.

Under the British National Health Service, all types of medical care, as needed, are provided free of charge to everyone in the country who wishes to avail himself of them. Since the National Health Service is not an insurance program, everyone in the country is eligible. Some 85 to 90 percent of the cost comes from general tax revenues, mostly from the national exchequer, although part of the cost comes from the local health authorities. The remaining 10 to 15 percent comes from the national insurance fund, to which those (practically everybody in the nation) covered by the other social-insurance measures of the country contribute.

The range of services offered covers general practitioner and specialist services, complete in-patient and out-patient hospital care, convalescent and rehabilitation treatment, optical and dental care, and home nursing. Prescribed drugs and medical appliances, including spectacles and dentures, are also supplied. The only services for which there is a direct charge are those not needed on medical grounds, such as private hospital accommodation, except when necessary for the welfare of the patient, or more expensive types of appliances or spectacle frames. I might also add that there is a charge for replacement of spectacles or other appliances made necessary because of the carelessness of the patient.

As was the practice in Britain prior to inauguration of the new service, the usual channel to most types of medical care is through the general practitioner or family doctor. He provides the ordinary general practitioner services in his own office or in the home, or may refer the patient for hospital or specialist care. A patient may select any general practitioner participating in the service in his area and if the doctor accepts him, is placed on the doctor's list which entitles him to that doctor's services. The patient may change doctors for any reason. Likewise, the doctor may refuse to take any patient or may have a patient dropped from his list. Neither doctors nor patients are compelled to participate in the public service, both being free to make private arrangements as formerly.

The services of specialists are usually provided through the hospitals. Optical services will eventually be incorporated with the specialist services in the hospital, but until they are patients are certified by the family doctor for care by any participating optician. Present arrangements for dental care are also temporary, for dental clinics will eventually be set up for this service. At present a priority dental program is operated by the local health authorities for expectant mothers and young children but others go directly to any participating dentist.

Perhaps the most striking fact about the operation of the National Health Service since it took effect last July 5 is the unexpectedly high proportion of both the medical profession and the public who are participating in it. Last April, the British Medical Journal stated that 20,000—which is well over 90 percent—of the country's general practitioners had signed up for the National Health Service either full- or part-time. This exceeded the expectations of both the profession and the Government.

This unexpectedly high proportion of the general practitioners who are participating is not entirely due to their real desire to do so, for, while the right to continue in private practice is legally guaranteed, the opportunities for doing so have been sharply curtailed by the heavy proportion of the population who have sought care under the National Health Service. Various estimates placed the number of those who would continue to receive medical care under private arrangement at 15 percent or more. However, it has developed that 95 percent of the population have signed up for the public service, and some estimates published last April in the British Medical Journal place the proportion as high as 98 percent. The numbers of those participating has been particularly surprising in the wealthier districts. The more affluent doctors formerly drew their patients from the wealthier 10 to 15 percent of the population, but obviously many of these, too, have sought medical care under the new scheme. Exponents of the National Health Service in England look upon this development as salutary on the theory that the wealthier groups having been in the habit of demanding and receiving the highest quality medical care, will help maintain standards under the National Health Service.

The same story is true of other branches of the service. Approximately 92 percent of the estimated 12,500 dentists in England, Scotland, and Wales have joined despite the persistent advice of the British Dental Association to its members not to do so. Similar proportions of the estimated 6,400 opticians and 17,000 pharmacists are also reported to be participating.

What has this heavy enrollment meant to medical practice and to the quality of care? It has, of course, placed a much heavier demand on all branches of medical service. The Lancet—a 125-year-old independent British medical journal—in a survey of the workings of the new act, estimated that the average number of those attending doctors' offices had risen by one-quarter to one-half. There are, no doubt, instances where the increase has been much greater, particularly in the heavily populated industrial centers.

The demands for hospital treatment have also been greatly increased. The Lancet survey of the hospital services estimated that the number of those now seeking hospital treatment is about three times what it was before the National Health Service began. The waiting lists of most hospitals have been greatly lengthened, the most difficulty being experienced in efforts to care for the chronically ill or those likely to become chronically ill. For certain types of treatment not immediately urgent, the waiting period may often run to many months, although most hospitals reserve about 10 to 15 percent of available space so that emergency cases can be dealt with at once.

Some of the heaviest increases have been felt in the dental and optical services. Most dentists are booked up several months in advance and the waiting period for spectacles runs on the average to from 4 to 8 weeks and sometimes longer. The latest official figures quoted recently by the British Medical Journal were that for the first 6 months of the National Health Service 3.4 million persons had received or were receiving dental care and 2.5 million had had their sight tested. Spectacles were being ordered at a rate close to 8 million pairs per year, over twice the former number and 40 percent above the Government estimates.

Much of the adverse criticism of the British National Health Service is based on the present shortages of personnel and facilities to meet at once all demands placed upon them. In our own country, critics point to this as grounds for condemning the whole system. In Britain, it was fully realized that medical resources would not at once be sufficient for all needs, for there were shortages prior to July 5. For the period during which resources were being brought into balance with demand, the decision had to be made as to whether what facilities there were should be immediately accessible to everybody on the basis of physical need or whether they should be rationed on some priority basis. There were and still are differences of opinion as to what should have been done. The action of the Government was to give access to existing resources to everybody on the basis of physical need with the exception of the dental services where, because of extreme shortage, a priority system was established for expectant and nursing mothers and young children. Also, many were of the opinion that removing any economic or other barrier to medical care would expose existing resources to the full needs of the entire population and act as the most powerful stimulant to speedy and adequate provision of the resources really necessary.

While it is possible to quarrel with this approach, it must be recognized that it is a question of approach and not a question of the ultimate effectiveness or ineffectiveness of the National Health Service. Even if Britain were to curtail certain services temporarily on some priority basis (which I hasten to add is not being considered) such action would not of itself be grounds for condemning the entire program—as many would no doubt do—but only for criticizing the method the British Government took to launch its new program.

Most of the complaints with respect to the strain on the nation's medical services appear to be coming from the general practitioners and it is undoubtedly true that many of them are heavily burdened. Much of this difficulty arises from the present maldistribution between the general practitioners and the population, a problem which exists under any form of medical practice but which is thrown into bold relief by a program like the National Health Service. The Lancet states that a family doctor should be able to care for from 2,000 to 3,000 patients adequately depending on the temperament of the doctor and the geographic and other characteristics of his practice. The ratio of the total population of England, Scotland, and Wales (48,000,000) to the number of general practitioners in the National Health Service (20,000) is about 2,400 but with the present maldistribution between the doctors and the population this theoretic average-size practice will not be possible for some time to come, and under present arrangements, a general practitioner in the National Health Service is permitted to take a maximum of 4,000 patients. Since the opportunity for private practice has almost disappeared, most doctors feel they must strive for that maximum under the method of straight capitation payment on which they insisted.

The ultimate solution of this problem lies not only in better distribution of the doctors but also in an increase of their numbers. It will take many years to increase the number of doctors although the medical schools are full to capacity. There is a central Medical Practices Committee, 7 of whose 9 members are medical practitioners, charged with responsibility of achieving better distribution of the doctors; it is this committee which designates areas as "overdoctored" in which new public practices may not be established or into which a doctor in the public service may not move. However, probably due to the strenuous opposition of the medical profession to this "indirect control" of their movements, there have been very few areas designated as "overdoctored" although this matter is scheduled for review.

The suggestion of many in the medical profession for coping with this problem is the speedier provision of the health centers. Health centers are called for in the plan for the National Health Service. They will consist of technically equipped premises, constructed and staffed at public expense where general practitioners and dentists in the service will see their patients. Nurses, clerical staff, and other auxiliary personnel will be provided to relieve the doctor of much of the routine parts of his job, including the much discussed certification and paper work, which can as well be done by others under his direction. So far, there is one health center in Birmingham, several others have been approved for the London area and plans are being submitted for health centers in other sections of the country. It is estimated that working in a health center would conserve about 25 percent of the doctor's professional time. Editorial comments and letters in the columns of British medical journals indicate that the doctors do not believe the construction of health centers is being given the priority it deserves.

Contrary to some reports here, the Lancet in its survey of the operation of the National Health Service stated that "every account agrees that frivolous complaints (being brought to the doctor) are no commoner than before." Also, dishonesty under the system is rare, although cases that have come to light are widely publicized. The most common complaint among the doctors regarding the type of ailments they are asked to treat was put this way by Dr. Dain, chairman of the council of the British Medical Association: "No longer are we called upon to see a patient; we are called to see a family." Whether a doctor is called in or visited, no financial barrier remains to his being asked to advise on other members of the household. Not all doctors, however, look upon this as bad. As one general practitioner put it in a recent issue of a British medical journal * * * "there will never be preventive medicine unless patients are encouraged to take occasional risks with the doctor's valuable time * * * It is useless to preach prevention rather than cure without offering practical help in bringing the preventable to the doctor's notice in good time."

Judging by the amount of space devoted to it in the last several months' issues of the British Medical Journal, the subject uppermost in the minds of the general practitioners at the moment is that of remuneration. The remuneration of the general practitioners, specialists, and dentists in the National Health Service was based on recommendations of a committee under the chairmanship of Sir Will Spens, of Cambridge University. The Spens committee surveyed the incomes of medical practitioners earner prior to the war and made recommendations, in 1939 money values, of the amounts and the distribution of incomes which should be achieved under the National Health Service. These recommendations were accepted by the profession and the Government and the method and amount of payments in current money values were negotiated by the Government and the profession.

General practitioners are paid according to the numbers of persons on their lists for whose care they have accepted responsibility. For each person, the doctor receives a flat annual sum, or capitation fee, of about 17 shillings 6 pence ($3.46) regardless of how much or how little service the person required during the year. Doctors who receive the basis salary are paid 300 pounds ($1,200) per year plus capitation fees reduced by one-seventh the normal amount. There are also special payments to general practitioners for treating emergency cases, maternity cases, for the administration of anesthetics, and in certain areas mileage payments for home calls.

At present, dentists are paid on a fee-for-service basis, according to a set scale for each service rendered. Opticians are also paid on a fee basis, according to a scale fo reach item of service. Specialists in full- or part-time service are paid on a salary basis, ranging up to £2,750 ($11,000) per year for a full-time specialist. Special awards are given to about one-third of the specialists, bringing the maximum salary of a specialist up to £5,250 ($21,000) per year.

Exact figures on the distribution of the incomes of the general practitioners are not yet available for the period from July 5 to March 31, the end of the British fiscal year. Nevertheless, there is clear indication that there have been substantial shifts in income both ways: those working in congested areas with the maximum 4,000 patients are reported to have experienced a 25 to 30 percent increase in income, while those in thinly populated areas or in wealthier districts with fewer patients have had substantial reductions.

Last March, the General Medical Practices Committee—the central body concerned with the distribution of doctors—submitted a report to the Minister of Health pointing out the dissatisfaction of the general practitioners with the remuneration. The report stated that in general the objectives of the Spens commmittee recommendations were being achieved with respect to the doctors in the 40–49 age group, but that there were too many low incomes among the group under 40 and too few high incomes in the group over 50. It recommended an increase in the fund for payment of the general practitioners and the increase be used to raise the capitation rate for the first 1,000 or 2,000 patients on the doctor's list.

Another aspect of the dissatisfaction of the general practitioners in respect to remuneration is the inequity between what some of them are earning as compared with some of the dentists. As I have mentioned, the dentists are presently paid on a fee-for-service basis, what most students of this subject believe to be the most ineffective way of remunerating doctors under a national medical care program. The recommendations of the Spens committee for the dentists were based on a 33-hour week at the dentists' chairside plus added hours for other work, which the dentists agreed was a fair amount. However, no maximum was placed on the number of patients or the amount of work a dentist could undertake. A few months after the service began, it developed that many dentists were working double, or almost double, the 33 hours at the chairside and grossing much larger incomes in relation to the general medical practitioners than was anticipated or intended. On the grounds that the number of hours these dentists were spending at the chairside would impair efficiency, the Minister of Health, as of the first of this year, cut the payments above £4,800 ($19,200) per year by 50 percent. This allows full payment up to 42 chairside hours per week or 9 hours above that recommended by the Spens committee and accepted by the dental profession.

There seems little question that these inequities which have emerged in the remuneration of the doctors need to be reviewed in the light of this experience. This seems likely in view of a recent announcement by the British Medical Journal that the Minister of Health has been collecting the exact figures on the distribution of incomes among the general practitioners from the 138 local executive councils where the actual payments are made.

Fundamental to an appraisal of the National Health Service is the effect it is exerting on the quality of medical care. It seems to me reasonable to suppose that when the medical resources of a country are admitted to be in short supply, suddenly making them available to the entire population is bound to lower the highest quality and quantity of service formerly accessible to a limited section of the population, while for those who formerly did without or nearly without, it would mean an improvement. It is, therefore, not surprising to me that we are receiving conflicting reports that the quality of care under the National Health Service has both been improved and lowered. Undoubtedly, there is truth in both reports. As to how the quality of care is affected, the Lancet expressed the view that "at one pole, the acutely ill patient, and at the other the person with mild bronchitis are likely to fare no differently than before," but that the differences would be felt between those extremes.

The criterion by which to judge the quality of care under the National Health Service seems to me not whether the many are now receiving the benefit of the highest quality of care formerly accessible to the few, but whether the mass of people are on the whole receiving better care. There is substantial evidence that they are. Most impartial observers of the National Health Service admit that every illustration of lowered quality of care can be more than matched by the amount of undisclosed illness coming to light or by cases in which better care, or any care, is now being received which was not possible before. In the same Lancet article to which I have just referred, it was stated: "* * * the service has brought to light untreated illness in the old, in children, and in women. The amount of undisclosed illness is particularly large in women, many of whom have suffered for years without referring to a doctor * * *"

One final matter regarding the National Health Service which has received considerable publicity is the matter of cost. Preliminary estimates early in 1948 placed the gross cost of the National Health Service for the first 9 months of operation—July 5 to March 31, the close of the British fiscal year—at £198,000,000 ($792,000,000) including the amount from the local health authorities and the National Insurance Fund. Actually, however, the gross cost of the service during this period came to £275,000,000 ($1,100,000,000) or slightly less than 40 percent above the original estimates. In the debates in the House of Commons on these increases, it was pointed out that the original estimates were made several months before the actual salary scales were determined, but most of the increase was due to a much heavier demand in some branches of the service than was anticipated. More than half of it was because of dental and optical costs, where the original estimates were determined largely on what seems to me an unrealistic basis, namely, the amount of optical and dental services rendered under the old National Health Insurance scheme where these benefits were narrowly restricted.

The estimates for the first full fiscal year—1949–50—are £352,000,000 ($1,408,000,000) of which £268,000,000 ($1,072,000,000) will be a direct charge on the national Exchequer. The London Economist pointed out last March, when this estimate was announced, that it is a lower rate than the cost for the first 9 months since these early months included certain nonrecurring items, such as the financial liabilities of the hospitals which were transferred to the Ministry of Health when the service began. Also, expenditures in the pharmaceutical and ophthalmic services are expected to be at a lower rate during the present year, since the backlog of demand in these services is expected to level off during the current fiscal year. The estimate for 1949–50 represents about 3.6 percent of the British national income.

Whether this sum is an excessive amount beyond the ability of Great Britain to afford can hardly be answered on the basis of the first 9 months of operation, nor on the basis that the cost was substantially above the estimate for that period. The cost of the National Health Service is not a net increase since a considerable proportion of this sum was being paid by the nation for health services and for the care of the indigent sick prior to inauguration of the new program. In the final analysis, the cost of the National Health Service is a charge on the productive capacity of the country. If it eventually reduces the cost of production by conserving the nation's manpower and increasing industrial output, as many believe it will, the investment will then be economically justified. But, whether it will or not can hardly be determined for some time to come.

Early reviews of a new program such as the British National Health Service necessarily dwell on the major problems which have emerged and I have tried to touch on those most widely discussed. Most of these difficulties were anticipated before the National Health Service came into operation and it was generally well understood in Britain that many of them would have to be worked out over a period of time. Now, after several months, the great majority of those associated with the new service still believe that these difficulties can be remedied and that there is no inherent reason why the National Health Service will not eventually function smoothly. It is significant that there is no indication that Britain is considering abolishing its comprehensive medical care program regardless of what political party is elected in 1950, for the nation remains firmly convinced of its need, of its benefit and of its workability.

Many of the gloomy predictions before the National Health Service began have not materialized. There are no complaints of clinical interference on the part of the Government in medical practice; the doctor-patient relationship still remains undisturbed; the incentives of the medical profession have not been destroyed; the transfer of the hospitals to the Ministry of Health has gone smoothly and many believe that the hospitals in Britain have been given new life and scope; the numbers of those seeking admission to the country's medical schools have not diminished—if anything, they have increased; and, above all, more people are receiving medical care, or better medical care, than was thought possible heretofore.

In reference to what we can learn from British experience thus far, as to whether or not compulsory health insurance can work in the United States, I think a good answer was given by this paragraph in a dispatch to the New York Times early this year by Herbert Mathews, chief of its London bureau:

"* * * American critics or champions who look across the Atlantic for arguments to oppose or support President Truman's plan to introduce compulsory health insurance will find whatever they are seeking. The American Medical Association will be able to produce a mass of testimony from British doctors on how badly the scheme is working. Conversely, the Federal Security Administration should be able to compile a still more formidable body of testimony from patients, druggists dentists, and many doctors to prove that a nation of nearly 50,000,000 can take care of the health of every man, woman, and child from teething to senility * * *."

AMERICAN PHARMACEUTICAL ASSOCIATION,
Washington 7, D. C., July 11, 1949.

Hon. ELBERT D. THOMAS,
Chairman, Labor and Public Welfare Committee,
United States Senate, Washington, D. C.

DEAR SENATOR THOMAS: May we request that you include in the hearings and statements submitted by various organizations on the bills relating to medical care and the various health insurance programs the statement of the position of the American Pharmaceutical Association with respect to compulsory national health insurance, of which a copy is enclosed. It was our understanding that statements submitted up to and including July 15 would be included in the record of the hearings.

Thanking you for your courtesy in this matter, we are

Respectfully,

AMERICAN PHARMACEUTICAL ASSOCIATION,
ROBERT P. FISCHELIS, *Secretary.*

cc: Mr. Earl B. Wixcey, Clerk, Labor and Public Welfare Committee, United States Senate (attention: Mr. Philip R. Rodgers).

STATEMENT OF THE POSITION OF THE AMERICAN PHARMACEUTICAL ASSOCIATION WITH RESPECT TO COMPULSORY NATIONAL HEALTH INSURANCE

The issues involved in determining the best means for providing adequate medical care to all segments of the population are sufficiently urgent as to require all medical-care professions to make their position clear. The American Pharmaceutical Association does so herewith.

It is recognized that public interest in this subject is becoming more intensified day by day. Much information, both true and false, is being publicly disseminated with the result that there is need for clarifying the issues insofar as this is possible.

Not only should the issues be clarified, but they should be rationalized in terms of traditional American principles. Compulsory national health insurance should be examined in the light of what compulsion in this field has accomplished abroad and also in the light of the changes which it might conceivably bring about in our democratic principles.

If, as is so strongly contended by some, compulsory national health insurance would bring about the socialization of medicine, it would seem totally unsuited for solving our problems of medical care.

Once this socialization program is adopted and enacted into law it might well be the opening wedge for related movements which might seek the socialization of broad areas of industrial and professional activity.

Ours is not a socialistic country, and there would seem little justification for resorting to untried socialistic experiments for meeting health needs of our people.

There is, of course, no proof that such would be the consequence of compulsory national health insurance. On the other hand it should be pointed out that this means for providing medical care has been largely confined to socialistic countries where it gave rise to or became a part of broad socialistic movements.

It must be admitted, too, that there are basic defects in the prevailing system of medical care. There are certain segments of the population and certain sections of the country for which adequate medical care is not available. This deplorable fact is due in large degree to a low economic status and to conditions which are not conducive to good medical care.

There are, perhaps, millions of our people who cannot, of their own resources, provide for themselves anything approaching adequate medical care. There are some parts of the country which are so devoid of satisfactory hospital and clinical facilities as to be highly unattractive to medical men who are accustomed to relying upon scientific diagnostic laboratories such as the modern hospital provides.

Obviously these two situations, not to mention others, constitute a challenge which must be met. Such conditions are utterly inconsistent with enlightened concepts of social and professional responsibility. These defects must be corrected as a matter of common justice and common decency. The question is as to the best method to pursue.

The American Pharmaceutical Association is of the opinion that competent surveys should be made of medical-care conditions in each State and a workable program devised on the basis of the factual need. Such a survey would seem to be necessary as obviously conditions vary from State to State and between sections of the same State. Until the facts are established it would seem foolhardy to adopt a national health-care program based upon sheer generalities when specific programs suited to specific needs are so urgently required.

The American Pharmaceutical Association is opposed to compulsory national health insurance on several grounds:

Among these are its dubious value when seen against the background of American democratic processes; the apprehension that it would lower standards of medical care and probably make it still more difficult to obtain; the fear that it would impair medical education and stifle medical research; a conviction that it would politicalize medical services thus demoralizing the field; a certainty that the costs would be fantastically high, with no one knowing what might be the ultimate tax burden upon the public.

The American Pharmaceutical Association is also of the opinion that compulsory national health insurance, while applicable at the outset to the medical profession only, would in due course socialize or nationalize pharmacy, the drug industry, and all cognate branches of medical care. The costs of all phases of medical care would, in time, have to conform to the financial exigencies of the insurance program. Certain restrictions, many of them undesirable, would inevitably be placed upon the scope and nature of medical services if the costs were not to rise to confiscatory levels.

The American Pharmaceutical Association holds to the conviction that voluntary health-insurance programs should be encouraged by the Federal Government and the public and should be expanded and amplified as rapidly as possible. These voluntary programs should be examined to determine their flexibility and also to ascertain how fully they do, or can meet the over-all health needs of the insured.

If these voluntary plans do not supply adequate coverage at a cost within the reach of those most in need of it, they should be revised so as to provide this coverage at this cost. Partial coverage at high cost cannot meet the requirements for adequate medical care. This phase of the subject should be inquired into promptly and proper steps taken to correct whatever defects may be found.

The American Pharmaceutical Association is also of the opinion that once health conditions and medical facilities in each State have been competently surveyed and evaluated medical-care programs should be devised to meet the needs specifically shown.

It may well be that governmental participation would be required to provide hospital and diagnostic facilities and to aid in securing physicians and other health care professions to participate in those areas now so much in lack of them.

The nature of this participation should be carefully studied so as to assure its being consistent with sound medical administration.

It may be, too, that surveys are required to ascertain the number of medically indigent in all portions of the United States. Once the facts are in hand, some plan should be worked out with governmental support and cooperation for providing the medically indigent with adequate medical care.

This should be done not on a charitable basis, but as a matter of right. This country should be intelligent enough and resourceful enough to see to it that adequate medical care is denied none.

In this phase of the subject, however, the Federal Government should supplement activities of the medical, pharmaceutical, and other health professions rather than attempt to supplant them. Medical care is basically and essentially a medical problem. It can only be solved with the active support and understanding cooperation of the health professions.

It is the conviction of the American Pharmaceutical Association that greater progress would be made toward the solution of national health problems if they were regarded less from the standpoint of their political significance and more as truly medical matters.

The American Pharmaceutical Association holds the view that compulsory national health insurance would retard rather than advance fundamentally sound contributions to medical care. It is too inconclusive, too unsuited to the American way of doing things to be relied upon in correcting the defects in medical care. Whatever plan is adopted must be consistent with the professional ideals and objectives of medicine and in harmonious accord with those social and political concepts to which this country owes its progress and its greatness.

This is not the time to encourage socialistic experiments either in medical care or in any other phases of our national life. This is not the time to centralize in Washington control over the medical profession, medical education, and medical research. Rather, every attempt governmental and otherwise should be directed at strengthening medical care within the limits of free enterprise. Once personal initiative is stifled or emasculated it can no longer be depended upon to give the American people those high standards of medical services to which they have long been accustomed.

While the American Pharmaceutical Association is opposed to any attempt to socialize or nationalize the field of medical care, such as would be the likely effect of the adoption of compulsory national health insurance, it recognizes the urgent need of providing adequate medical care to all within the framework of free enterprise medicine.

The realization of this objective is so basic to the perpetuation of American constitutional principles as to command the cooperation of medicine, pharmacy, the drug industry, and all other professional and businessmen who are devoted to traditions which have given us the highest standard of living anywhere in the world.

NATIONAL ASSOCIATION OF MUTUAL INSURANCE AGENTS,
Washington, D. C., July 11, 1949.

HON. JAMES E. MURRAY,
Chairman, Senate Labor Subcommittee on Health and Public Welfare,
Senate Office Building, Washington 25, D. C.

MY DEAR SENATOR MURRAY: Due to the fact that I was unable to appear in person to testify before your committee, on behalf of the National Association of Mutual Insurance Agents, in connection with pending health legislation, I wish to take this opportunity of filing a written statement with your committee.

I trust that you will find it convenient to include this statement in the record, as reflecting the views of our association concerning the Nation's health and future welfare.

Please accept my congratulations upon the fair and impartial manner in which you have conducted the "health hearings." I believe that the opinions, statistics, and recommendations you have accumulated will be of tremendous value in formulating constructive legislation regarding this vital national problem.

With warmest personal regards,

Sincerely yours,

HUGH G. MURRAY, Jr., *President.*

STATEMENT OF HUGH H. MURRAY, JR., RALEIGH, N. C., PRESIDENT, NATIONAL ASSOCIATION OF MUTUAL INSURANCE AGENTS, ON PROPOSED NATIONAL HEALTH INSURANCE LEGISLATION

My name is Hugh H. Murray, Jr., of Raleigh, N. C. I am president of the National Association of Mutual Insurance Agents, composed of more than 3,200 mutual insurance agents operating as small independent businessmen in all parts of the United States.

At the outset, I wish to state that the association I represent is categorically opposed to all of the proposed national health insurance programs, as such, when considered each in its entirety.

However, in practically all of the legislation on this subject now pending before your committee and the comparable committee in the House, there are contained certain provisions which we heartily endorse as being in the future interest and welfare of this Nation from the standpoint of health and longevity.

I refer to those provisions for aiding and fostering the education and development of a great number of physicians, dentists, and nurses, and for providing erection of vast numbers of hospitals and clinics throughout the country, both urgently needed.

We believe in "first things first." We don't want the cart before the horse.

It is an indisputable fact that there is a terrific shortage of doctors, dentists, and nurses in the United States.

No one denies that there is a vital need for more hospitals and clinics. Everyone agrees there is urgent need—now.

By the same token, gentlemen, there is agreement by all concerned, Democrats and Republicans alike, that no over-all health program can be passed at this session of Congress—and it's even doubtful about the next one.

Therefore, I desire to entreat you, on behalf of myself and the Association of Mutual Insurance Agents I represent, all outstanding businessmen in every section of the country—we appeal to you to separate these two vital necessities to our future health and welfare, from the very controversial issues about other phases—and pass them now—at this session—without any further delay.

Providing adequate personnel and hospital facilities will require at least 4 years. You can be deciding the Health Program issue while these vital needs are being provided. If you passed 10 national health programs tomorrow, they couldn't be operated because we don't have the medical personnel or the hospitals.

In expressing opposition to the "complete" health programs as offered in pending legislation, I do not care to criticize them as socialized medicine nor as a trend towards communism, as has been done by so many witnesses who have preceded me. We view these labels as a play upon ignorance, a generalized label which has no place in a hearing of this nature—of such vital importance to every man, woman, and child in the United States.

We believe that these health programs, whether mandatory or voluntary, cannot and will not lend themselves to workable administration without an expense totally unjustified from any standpoint. In other words, our association believes that the administrative costs of bringing a patient to the proper doctor's office, or to a clinic or hospital for treatment, would create a tax burden out of all proportion to the benefits which might be expected from these programs.

We have just grounds for these fears. We have a record of Government efforts for 15 years or more to control, direct and allegedly promote and foster construction of residential housing in the United States. Actually, billions of dollars have been spent for administrative cost; huge technical and clerical staffs have been created and maintained at taxpayer's expense—are still largely in existence today all over the country—and the results have been negbigible.

We believe that adoption of any one of these over-all health insurance programs would necessarily result in the creation of similar top-heavy bureaucracies, with big technical and clerical staffs, functioning more for political than health purposes in the final analysis.

Our association believes that there is a simpler and far more economical means of meeting and solving the question of national health. We believe that the following legislative actions will solve the basic problems involved:

(*a*) By aiding the education and development of a tremendous number of doctors, dentists, and nurses.

Obviously, no health program can hope to accomplish anything without trained personnel to provide adequate medical attention. According to figures currently being quoted by Hon. Oscar R. Ewing, Federal Security Administrator, there is an appalling need for more doctors, dentists, and nurses in the United States. For example, he cites the fact that there is in Mississippi one doctor to every 1,500 of population, and one doctor to every 500 in New York.

In the opinion of health experts, even the New York ratio is too great for satisfactory protection o fthe Nation's health.

FSA Administrator Ewing goes even further, however, in pointing up the urgent need for more doctors. Speaking of the South, he cites the fact that throughout the entire South there is only one Negro doctor for every 4,900 patients, and in Mississippi the ratio drops to one in more than 18,000.

Obviously then, Mr. Chairman, the primary step must be to provide more doctors, dentists, and nurses. Our association believes that this step should be taken immediately, without attempting to connect it with any other phase of the health program. Even now, we feel, "it is later than you think." Doctors, dentists, and nurses, properly educated and trained, cannot be developed overnight.

They should be aided, subsidized, and encouraged in every possible manner. The professsions should be glamorized and high lighted by especially focussed programs to encourage youngsters to take up these professions. It is fundamental that no nation's health can improve or even survive without adequate medical personnel.

I believe this primary step needs no further elaboration on my part, except to point out that many additional medical schools much be created to meet this huge deficiency.

The next step in the program we favor, which I shall call item (*b*), concerns the necessity for providing adequate hospital facilities and clinics at which, or through which, these additional doctors, dentists, and nurses may minister to the country's health needs.

The providing of adequate hospital facilities in every section of the country—and there is no section where sufficient facilities now exist—should definitely transcend all considerations of politics. Diseases, epidemics, illnesses, know no racial, religious, or political subdivisions.

As in the case of our item (*a*), the hospital and clinic facilities cannot be developed overnight. Again, "it is later than you think."

This consideration should also be considered exclusive of any over-all health program. The indisputable need already exists.

Our association beseeches this Congress to forget all thoughts of such terms as "Dixiecrats," or "Republicans," or "Democrats," and every other consideration of politics, and pass separate legislation at once to provide doctors, dentists, nurses, and hospital facilities.

Our third and last thought on the solution of this problem may be called item (*c*). Each one of the so-called national health programs refers specifically to, and expresses great concern for "the medically indigent."

We believe that the solution to providing adequate care for the medically indigent lies within the scope, easily adopted, of an amendment to existing social-security legislation.

As matters now stand, no national health insurance program, whether mandatory or voluntary, whether "socialized" or otherwise, not only cannot function, it cannot even be logically conceived or put on paper with any degree of intelligence, until—

> (1) An adequate supply of trained medical personnel is available in every part of the United States; and
>
> (2) Until adequate hospital and clinic facilities are made available where this trained medical personnel can function.

Therefore, at this time, in voicing its opposition to the entire group of so-called national health programs, as such, the National Association of Mutual Insurance Agents respectfully implores the Congress to immediately divorce and pass separately such legislation as will act to provide adequate trained medical personnel of all types, and Nation-wide hospital and clinical facilities. When these vital needs are met, then will be time enough to consider national health programs.

STATEMENT OF THE NATIONAL ASSOCIATION OF RETAIL DRUGGISTS IN CONNECTION WITH NATIONAL HEALTH INSURANCE BY GEORGE H. FRATES, WASHINGTON REPRESENTATIVE, WASHINGTON, D. C.

I am George H. Frates, and I represent the National Association of Retail Druggists. The statement I am about to submit pertains to the proposed system of compulsory sickness insurance.

We wish to make it plain that we recognize the necessity for additional extension of facilities for the improvement of public health. The position we take is that it can be accomplished through traditional democratic procedures and that methods identified with ideologies of the police state must be avoided to maintain the structure of liberty in the United States.

We oppose national health insurance (compulsory Government sickness insurance) for the reasons as follows:

(1) It would be injurious to the profession of pharmacy and the drug store evolved in the United States. It is of a different pattern than the apothecary or chemist shops of Europe. The conditions of the pioneer period made it take the form that it did. It grew with the country and it followed the settlers to the remotest frontiers. To survive the drugstore took on the sale of products other then medicines. Thereby it was able to exist in areas of sparse population.

But pharmacy was then (as it is now) the heart of the drug store. It was the availibility of the facilities to have prescriptions filled in accordance with the best medical knowledge of the time that gave the drug store a place of importance in the community. And this has been further advanced through additions of educational requirements for the profession of pharmacy. The elevation of the standards is responsible for the excellence of the schools of pharmacy in the United States. They are the best in the world today.

Now, after long effort to raise pharmacy to the high level it occupies, the profession is confronted with the possibility of deterioration through Government medical services coupled to socialized medicine. Bureaucratic regimentation of pharmacy is certain to come with the proposed system of compulsory sickness insurance. The nature of the scheme warns us to beware of it.

One of the prominent advocates of compulsory sickness insurance insists that the profession of pharmacy will benefit from the system. He said in a recent address:

"When we cut through all the pros and cons of the argument over this program (provided for in S. 1679), one solid, and, to me unassailable fact emerges. And that is, under this program the drug industry stands definitely to gain in terms of volume of sales and profits." (Oscar R. Ewing before the sixty-seventh annual meeting of the Proprietary Association of America, White Sulphur Springs, W. Va., June 3, 1949.)

We had thought through that "unassailable fact" long before he uttered it. We looked ahead beyond it and we saw bureaucratic regimentation of pharmacy. The sirens of greed failed to lull us to favor a course toward the rocks of Government paternalism. Moreover we reject it because we believe it is hazardous to the fundamental institutions of liberty in the United States.

History tells us that bureaucratic regimentation sooner or later leads to complete socialism or communism or fascism.

We believe that should compulsory sickness insurance be established in this country it would be only a matter of time before Government dispensaries replaced the drug store.

(2) The cost of the proposed system of compulsory sickness insurance would be terrific: We oppose the proposed scheme called national health insurance because of the tremendous burden of taxes it would add to the heavy load the people now carry. To finance the system involves much more than "technical operations."

Nobody seems to know for certain what the cost the proposed program would total. The minimum estimates of the protagonists are low and for obvious reasons. The figures they give us are unreliable. They admit that the levy of 3 percent would cover but a portion of the cost of the system of compulsory sickness insurance more than the minimum estimates of $6,000,000,000. We think it is unwise to go by the guesses that come from the advocates of the scheme. The people ought to be told the truth about the cost of the system of compulsory sickness insurance.

It has been charged on numerous occasions that the opposition to the plan coupled to socialized medicine have exaggerated the probable cost.

Yet the protagonists have persuaded millions of people to believe the cost would be only somewhat more than is now paid for medical and hospital services. Mr. Ewing admits that the cost of the system of compulsory sickness insurance cannot be determined until it has been operative for some time. We are inclined to believe the cost to be twice the minimum estimates of the protagonists. Calculations based on the figures of the Veterans' Administration and the experiences of England suggest that the annual total of $18,000,000,000 for the first several years and from then on to the amount of 10 percent deducted from the pay check of every worker plus additional taxes. We offer the amounts of the calculations only to emphasize the importance of intensive study devoted to the cost of the proposed system of compulsory sickness insurance before it is too late.

(3) The possibilities of political exploitation are serious: We oppose the proposed compulsory sickness insurance system on account of the temptation it would offer for political exploitation. It might bring the greatest expansion of bureaucracy we have ever seen in peacetime. It is difficult to give accurate estimates. Even the protagonists of socialized medicine in attempts to minimize the number, tell us it would require many less than 300,000. "Many less" may mean 250,000, and that number divides to more than 5,000 additional Federal employees in every State in the Union. To political politicians this spells patronage. Every political party likes patronage and exploitation is a foregone conclusion whichever one is in power. Furthermore it is hard to believe that rival candidates for office would refuse to vie with each other in promises of more liberal benefits (less rigid requirements for benefits, longer periods of treatment), larger reimbursement for unemployment due to real or fancied illness and replacement of pay-roll deductions with larger contributions from the revenue of general taxes, until health and sickness is made a political football.

The deterioration in the quality of the medical services which would come in the wake of this political exploitation is indeed unpleasant to contemplate.

Here is an example to illustrate what we are inclined to think would happen:

A former officer of the United States Army just returned from England. He was asked about socialized medicine over there. The reply he gave is as follows:

"One of the friends I made in the period of the late war was a physician in the British Army. On a recent trip to London I made it a point to see him. He is now a physician of socialized medicine. The doctor invited me to play a game of golf with him though he had about 60 patients to take care of. He did it in a hurry.

"The physician commanded the patients with colds to stand up. Half of them rose to their feet. He instructed them to report to the nurse at desk No. 1 for tablets. Then the doctor directed the patients with rheumatic or arthritic pains to rise. He told them to go to the nurse at desk No. 2 for medicine. Three patients remained. He treated them in 15 minutes.

"Later on the golf course he told me that he was paid at the rate of 50 cents for each of the patients he handles."

Is that the kind of medicine we should adopt in the United States?

(4) The proposed system of compulsory sickness insurance is a further step toward complete socialism. Through the last two decades we have traveled a long way toward a controlled economy with the Government at the wheel. We believe in capitalistic enterprise and we feel that we have gone far enough in the direction of complete socialism.

It is time to take stock once more, to inventory the situation before we proceed further. It is folly to refuse to consider the fact that, once we go on, the road closes behind us, and then it may take the explosives of a revolution to blast a trail back to the liberty that built the United States.

You perhaps think we are disturbed too much over the potentialities coupled to the system of compulsory sickness insurance. Therefore, we quote from a publication of the International Labor Office (it perhaps has more information about medical and hospital plans than any other organization in the world).

The publication is entitled "Approaches to Social Security" and we quote from pages 50 and 51:

"The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors and dentists, nurses, and hospitals, find themselves engaged in the insurance medical services, which squeeze out most of the private practice on the one hand, and most of the medical care hitherto given by the public-assistance authorities, on the other. The next step to a single national medical system in a short one."

The available evidence sustains the observations of the International Labor Office.

(5) The system of compulsory sickness insurance is unneeded: We oppose the proposed program coupled to socialized medicine because we believe it is unrealistic. The highest quality of medical care in the world is provided in the United States. We contend that it can be provided for the people of every class inside the framework of private enterprise. It can be accomplished through extension of voluntary prepaid hospital and medical set-ups such as the Blue Cross and the Blue Shield plans. We know you have heard them belittled. It is probable the sneers came from individuals with fixed ideas on compulsory sickness insurance.

We have had a revolution in medical science since the turn of the century. Like the technical revolution of a hundred years ago, it requires time to develop practical mechanism, and also to make workable adjustments to a scientific revolution.

But the process of adjustment has made long strides. It will continue to give us the essentials of progress and the outcome before long is certain to be adequate medical care for everybody—and inside the structure of private enterprise. The movement toward the objective had attained considerable momentum before the outbreak of the hostilities with the Axis. The war slowed it. But now again it is in rapid motion—and we urge that nothing be done through legislation to obstruct the movement toward adequate distribution of the facilities of medical science—within the framework of private enterprise.

June 29, 1949.

We the undersigned request that these statements be incorporated in the hearings of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare on the medical bills (S. 1456, S. 1581, S. 1679, and S.1106).

Edward L. Young, M. D.,
Brookline, Mass.
John P. Peters, M. D.,
New Haven, Conn.

Comments on S. 1456—The Voluntary Health Insurance Act

This bill professes "to make a high quality of hospital and medical care available to all persons in each State." It proposes to achieve this end by two means: (1) By paying to private insurance companies the necessary premiums or part of the necessary premiums for persons who are entirely unable or partly unable, respectively, to pay these premiums from their own resources; (2) to induce those who can afford to pay to insure themselves through these same agencies. This is an extraordinarily circuitous route to a universal-health-insurance system. The method of administration is equally devious. Policies and principles established at the Federal level are to be carried out by State agencies via local agencies through the aforementioned private agencies with the Federal Government paying a large proportion of the administrative costs of each of these intermediaries.

Like S. 1581, this bill will require a means test to determine eligibility for complete support. The odium of this procedure is softened bv the provision that the identity of those receiving such aid is to be concealed. It proposes that for those who require partial aid, eligibility shall be determined as far as possible in advance of need. How this can be accomplished it is hard to see. For such uncertain risks as illness and disability no standards for the prediction of partial need can be established.

The only practicable criterion of predictable partial need would have to be the income of the individual. This would require a graduated means test. Since, however, the voluntary feature of this insurance is given primary importance, persons eligible for partial aid would have to apply for insurance before their eligibility for such aid could be determined. An obvious danger would be the likely tendency for people to apply for insurance and aid only when need for medical care arose. No voluntary insurance plan with sound underwriting principles could undertake to insure as individuals persons already suffering from illness or disability. Yet it seems doubtful if any applying individual, whether ill or not, could be refused under the terms of this bill. If all such persons must be accepted and full costs for their hospital and medical care paid by the State (as would seem likely under section 713 (a) (16)), then this bill would not be supporting insurance, but relief, not prepayment, but post-payment.

The bill is supposed to encourage employer participation and health service in rural areas, but nothing in the provisions of the bill seems to us to make such encouragement effectual. No provision is made to create additional facilities, to develop needed personnel, to stimulate the extension of group medical practice or the development of regional organization of health and medical services, all of which are essential if insurance plans, of whatever sort, are to be able to supply hospital and medical care to any greatly enlarged number of beneficiaries, especially in rural areas.

Our next objection to this bill is that its proposed benefits are limited to services rendered in or by a hospital. This excludes some of the major potentialities of modern medicine, namely, preventive medicine, confirmed supervision of health, and the early diagnosis and treatment of illness.

Furthermore, nothing is said in this bill that would assure subscribers to prepayment plans of service, rather than mere cash benefits. As Blue Shield and commercial insurance plans are now organized, a large proportion of subscribers are required to make additional payments, in addition to their premiums, to hospitals and doctors at the time service is received. It is extremely doubtful, in our view, that Federal tax funds may properly be used to subsidize the advertising and promotion costs of plans which merely pay a share of the patients' bills.

In our opinion, therefore, the effect of this bill would not be to encourage materially the enrollment of a sizable fraction of the population in voluntary insurance plans offering comprehensive medical and hospital benefits, and would not have any useful or beneficial effect upon the health of people generally.

Finally, we object strongly to the administrative provisions of the bill. First, like S. 1581, it violates the principle that tax funds should be expended through public officials who represent and are accountable to the taxpayers, since the Federal funds are, through the States, to be expended through private agencies, i. e., nonprofit insurance companies, which are not accountable to the public, and which may be efficiently or extravagantly managed, provide adequate or inadequate coverage, etc. Secondly, the requirement that a majority of both Federal and State hospital medical care councils must consist of professional persons is most objectionable. In any program supposed to be designed for the benefit of the public, control must rest in the hands of the public. It is traditional in this country and other Western democracies that professional persons shall not have final authority in any public program. We have always had lay school boards, boards of health, university trustees, hospital trustees, secretaries of Army, Navy, and now, Air Force. To turn administrative control of a program such as this over to representatives of the professions concerned would be a radical departure from one of the most respected principles of our democratic system.

We vigorously oppose this bill, believing that it is undesirable and unworkable and that its enactment would be disastrous.

Both S. 1456 and S. 1581 neglect entirely the need in a health program to provide cash disability benefits (benefits for unemployment by reason of illness and disability). Illness and disability involve a double jeopardy, depriving an individual of income at the very moment it is needed most to meet the costs of medical care. Without such cash disability benefits it is impossible to reap the full benefits of medical care. It is implicit in S. 1679 that such cash disability benefits will be secured through amendments to the social security laws. They will, however, except as certification is necessary, be separate from the service benefits. Such benefits are logical supplements to a system that offers broad or universal coverage. They can be easily integrated with such a system, certification becoming practically automatic. Since they apply only to the employed, they also become a natural part of the social security payments to be shared between employer and employee. They cannot be linked in the same automatic way with a voluntary system. Sharing of premiums between employer and employee could not be limited to insured persons. This would place insured persons at a disadvantage in seeking employment. Few employees could or would afford to support subscripion charges for both service and cash disability benefits. To extend social security benefits to include cash disability benefits for all employed persons, insured and uninsured alike, would be both uneconomical and inefficient. Special machinery would have to be set up for certification of disability, because medical care for the disability would not be assured. Moreover, the Government would be ill-advised to furnish benefits for disability if it had no assurance that measures would be taken to curtail and minimize the disability. Cash disability benefits without service benefits would inevitably be used in large part to pay for medical services. Such a system would tend to degenerate into a cash indemnity system of medical care which would needs be of poor quality.

Both S. 1456 and S. 1581 advocate subsidized medical care with subsidies graduated according to need. If estimates of need are even approximately correct, either a large proportion of the people will require these subsidies or the medical care required will be of inferior quality. If, as is generally believed, the discrepancy between incomes and costs of medical care is increasing, the numbers needing aid and the amount of this aid will also increase. There will be large marginal groups continually shifting in and out of the subsidized system and between partial and total aid.

Comments on S. 1581—National Health Act of 1949

This bill, as far as its programs for reorganization of Federal health agencies and for the provision of medical care are concerned, follows closely S. 545 and is open to the same objections.

TITLE I. NATIONAL HEALTH AGENCY

The existing welfare agencies have been recently consolidated under the Federal Security Administration. There seems no good reason on the plea of furthering coordination to dissolve this organization again, especially when this involves the institution of a new administrative office and additional agencies under this office. The provision that the National Health Administrator be a licensed physician will not assure the appointment of the person most able to direct the diverse activities of the contemplated agency. The functions of this office extend far beyond the field of medical care alone. To allocate the programs for care for the needy, examination of children and maternal and child health to new agencies when there is already established in the Federal Government an agency, the United States Public Health Service, which has had broad experience in the administration of medical care for the needy, violates the principles of efficiency and the best interests of health. The aim of any forward-looking program should be to link the preventive machinery of public health closer to the service functions of medical care, not to separate the two further. It is a strange inconsistency to stipulate that the State health agency must administer and supervise each plan, but at the Federal level it must be supervised by an agency of an entirely different nature.

TITLE II. GRANTS-IN-AID FOR EXTENDING MEDICAL, HOSPITAL AND DENTAL SERVICES TO INDIVIDUALS UNABLE TO PAY THE WHOLE COST THEREOF; AND FOR OTHER PURPOSES

Purposes

This title, which contains the provisions for medical care, follows the same principles as did S. 545. It differs from the earlier proposal, however, in certain respects. Medical and dental services are not separated at the administrative level. Provisions for periodic health examinations of children are placed under a separate title. The title proposes by grants-in-aid to the States to provide medical, dental and hospital services for those persons who cannot meet the costs of these services from their own resources. Like the former bill it expressly states that partial as well as total costs may be provided. It is essentially a medical relief bill. Provision of dental services is optional with the States, perhaps in recognition of the inadequate personnel and facilities presently available. There are provisions for the promotion of nonprofit insurance plans, diagnostic facilities and aid to rural areas, but the inclusion of these in State plans is also optional.

Financial

Appropriations for surveys of medical resources and needs are desirable. Unless all previous surveys are erroneous, it may be anticipated that they will prove that the appropriations for the medical-care program are utterly unrealistic and inadequate, if this has been drawn ingenuously and its intentions are to be literally interpreted.

Conditions for receipt of grants

To require the States to submit plans in order to qualify for grants is highly desirable. The specifications for these plans are, on the whole, well conceived: Organization under a single State health agency with advisory councils and with necessary authority; an inventory of existing facilities, assurance of financial responsibility by the State; limitation of residence requirements and prohibition of discriminatory practices. The most important departure from the former bill is the establishment of standards for qualification on a merit basis. Such provisions, omitted from S.545, violated the first principle of sound democratic government, that agencies dispensing public moneys should be held responsible to the people for the quality of what is purchased. The possession by the Federal agency of regulatory powers with respect to the quality of personnel and facilities will not restrict freedom of experimentation in the States. It will only insure that this experimentation be conducted on a decent plane. Direct interference by the Federal authority with State or local autonomy is enjoined.

Administration

A Director of Medical, Dental and Hospital Services is to be appointed to conduct the program through a special office separate from all other health services including Public Health. It is stipulated that he must be a licensed physician. The inadvisability of such a separation has already been mentioned. The Director is to have a National Health Council composed of 12 persons of whom 3 must be doctors of medicine and one a doctor of dentistry. Another 4 members must be experts in medical, hospital and dental care; the remaining 4 shall be persons familiar with the needs for medical, dental and hospital care in urban or rural areas. Only this last category presumably would be representative of the consumers' interests. Considering the number and importance of the auxiliary services that will be involved in the program, undue weight has been given to purely professional representatives (a total of 9 out of 13, including the Chairman). The authorization of expert committees at the operative level would be advantageous. It is at this level, not at the policy-making level that professional representatives are most useful. This program is intended to benefit primarily the public, not physicians. In addition there is no adequate definition of the functions of the Council nor provision that its services must be utilized.

Nature of services and coverage

The utilization of nonprofit insurance agencies violates the principle that tax funds should be expended through public officials who represent and are accountable to the taxpayers. In this instance this responsibility is twice removed because the Federal funds are delegated to the States by which they may be dispensed through these private agencies. The interpolation of intermediary agencies between the State and those who provide the services cannot fail to multiply expense, thus tapping off some of the funds intended to meet the costs of these services.

The nature of the provisions for medical-care services are not devised to make medical, hospital, dental, and public-health services generally available, nor even to accelerate the approach to this objective. It follows the formula of relief bills adapted to emergency correction of economic errors, not to the prevention of such evils. The program requires the imposition in each State of a means test, which is inherently offensive to democracy. Such a test is not only objectionable, but unrealistic, when it is applied to a service linked with such an uncertain risk as illness or disability. If the terms of the bill are to be literally interpreted, eligibility for aid will be unpredictable, because the costs of illness are not, like those for the other necessities of life, fixed or proportioned to general price fluctuations. The costs of catastrophic illness are within the means of only a small fraction of the population. The remainder will be shifting in and out of the eligible class continuously. Such changes of status, moreover, will be necessitated in the very course of illness, which will create insurmountable difficulties.

It is unreasonable to expect that those who are not unconditionally eligible will secure protection through private insurance. If this is desired compulsory insurance is the logical solution. Under the provisions of S. 1581 the uninsured who, through illness or disability are reduced to poverty, will become a charge upon those taxpayers who are insured, thereby imposing upon the latter a double penalty, which will tend to discourage voluntary insurance.

This bill does nothing to meet the popular demand for a change in the present system which will give the majority of our people access to better medical care and allow them to enjoy in fuller measure the benefits of modern advances. It gives no consideration to the quality of medical care or its improvement. It only promises access to charity services through the indignity of a means test to those who, through illness or disability may suffer economic losses. The large proportion of the population, in other respects self-sustaining, that has not a large enough economic margin to be expected to pay for the costs of its own care, even through voluntary insurance, has been neglected. Unless even the most conservative estimates are faulty the appropriations proposed cannot provide for this large group. This title appears to have been devised, not to provide more and better medicine for the people, but to relieve physicians of part of the burden of charitable services.

TITLE III. HEALTH SERVICES FOR SCHOOL CHILDREN

Although periodic health examinations for children cannot be decried, experience has demonstrated that they are of no great value unless they are coordinated with provisions for remedial therapy. In this title provision is made for such remedial therapy for children whose parents cannot provide the necessary treatment. It may be accorded to all school children. There are, however, no specifications for the preservation of the quality of the services nor for the coordination of diagnostic and therapeutic functions. The size of the authorized appropriations are not adequate if an effective preventive program is desired.

TITLE IV. AMENDMENTS TO HOSPITAL SURVEY AND CONSTRUCTION ACT

It has required only a short experience to prove that there was an urgent need for this act, but that, as originally drafted, it had underestimated the magnitude of this need. In addition the rise in costs which has followed its enactment was not anticipated. This is recognized in both S. 1581 and S. 1679. In both bills it is proposed to increase the annual appropriations from $75,000,000 to $150,000,000 and to extend the life of the act beyond the original limit, June 30, 1952. S. 1581 suggests an extension of 3 years, S. 1679 would make this 5 years. Since there is agreement on the necessity of enlarging the sums and upon the necessity of some extension, it should be possible without delay to secure action that will meet immediate needs. Additional facilities are essential whether a Health Act is passed or not. We hope that the amendments will be drawn with sufficient imagination and generosity to meet the future needs of a comprehensive program.

TITLE V. LOCAL PUBLIC HEALTH UNITS

The provisions of this title are identical with those of S. 522 introduced by Mr. Hill on January 17, 1949. We recognize the need for the extension of basic full-time public health services throughout the Nation. This legislation also should not be delayed in behalf of more controversial measures upon which it is not inherently contingent. We believe this title is more soundly conceived than the corresponding title V of S. 1679, in spite of our adherence to the medical-care program of the latter. It is hoped that all those sincerely interested in the promotion of health may unite in securing its early enactment.

TITLE VI. STUDIES AND GRANTS FOR INCREASING AVAILABLE MANPOWER IN THE HEALTH PROFESSIONS

This title proposes to subsidize medical schools in proportion to their enrollment of students as a means of aiding them to support the general costs of education. It offers a premium for students in excess of previous enrollment in order to increase the number of physicians. The methods and purposes of this title are similar to those of part A of title I of S. 1679, except that it limits aid to medical schools for the education of medical students, while S. 1679 includes similar provisions for the education of students of dentistry, nursing, public health, and sanitary engineering.

We have considered the question of the need for Federal aid to education with relation to S. 2588 and S. 1679. We recognize the necessity and at the same time the inadequacy of the type of aid proposed in title VI of the present bill. Such a measure could be regarded as a first emergency step toward a broader, well-considered program. The sums recommended in S. 1679 per medical student, old and new, differ greatly from those in the present title. Since again there is agreement on principle, it should be possible for all parties to arrive at figures that would be effective in increasing enrollment while at the same time safeguarding and improving the quality of medical school education. The need of providing similar aid to the education of auxiliary professions should be searched in the same spirit. But aid of this type should be considered as only a stopgap.

GENERAL CONCLUSIONS

Concerning the main provisions of S. 1581, embodied in titles I and II, we can only reiterate what was said by the Committee of Physicians for the Improvement of Medical Care of similar measures introduced by Senator Taft and associates in 1946 and 1947 (Statements No. 21 and 23). "The bill fails not only to provide a national-health program, but also to establish a foundation upon which a program can be built. It is not conceived in terms that promise to improve the quality of medical care. It does not facilitate the access to this commodity of that part of the population most in need of it. Its administration would be difficult and excessively costly in terms of the benefits to be obtained. It is an undemocratic measure full of features that will foster extravagance, waste, and abuses."

It is our studied opinion that S. 1581 is an unsatisfactory measure. We therefore strongly oppose the passage of this bill.

Certain titles for which it has been made the vehicle, notably titles IV and V, are common to other bills which have been presented. They are sound and not strictly contingent upon the medical-care programs. They should, therefore, be withdrawn from these frames and enacted without delay.

COMMENTS ON S. 1679—NATIONAL HEALTH INSURANCE AND PUBLIC HEALTH ACT OF 1949

So far as provisions for general medical care for the needy and the health-insurance program are concerned, the present bill adheres closely to the principles of S. 1320, presented in 1947. In addition, however, it presents certain new or expanded features that seem intended to meet the argument that personnel and facilities are not available for the conduct of such a comprehensive national program as the bill contemplates. Chief among these features are the provisions for education and research in titles I and II, expansion of the hospital-construction program in title III, and special aid for rural and other shortage areas in title IV. The need for such provisions has been rendered more acute by rising costs which have followed the war and the present shortage of personnel.

Whatever faults may be found in these supplements, their introduction illustrates again the receptiveness of the proponents of this legislation to constructive criticism and their earnest desire to meet such criticism by constant improvement of their legislative proposals.

GENERAL PURPOSES

With the definition of the need for a national-health program and the general statement of the principles upon which such a national-health program must be based, we wish to express our sympathy.

TITLE I

Since part A of this title in its principal features follows the pattern of S. 2588, which was the subject of statement No. 27[1] by the Committee of Physicians for the Improvement of Medical Care, Inc., the reader is referred to that statement for a general discussion of the need for governmental aid to education and the course this should take. In this statement the specific provisions of this title will be discussed on the basis of the considerations raised in the Committee of Physicians Statement No. 27. This discussion will again be confined chiefly to the provisions that deal with medical education, about which the authorities can claim some right to an expert opinion. This opinion may have general significance with respect to those features of the bill in which provisions for training in all professional fields are uniform.

Part B, being an entirely new proposal will be given separate attention.

Purposes of part A.—We recognize the need for Federal aid to education in medicine and the allied professions and welcome the presentation of a proposal that may serve as a basis upon which legislation to provide such aid may be built. It may be presumed that sanitary engineering has been added to the other categories mentioned in S. 2588 because need for expansion in this field has been demonstrated. If this is the case, evidence of the fact will undoubtedly be presented in these hearings.

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[1] Statement No. 27 is attached with the paragraph referred to marked.

Like S. 2588 the present measure lays major emphasis upon multiplication of personnel. Although this is not only desirable, but essential, it is not an adequate objective; it must be linked with efforts to improve the quality of the human product. The bill is contrived essentially to increase the numbers of practitioners only, since the financial aid which it offers to both students and schools is confined to the formal school course. While the subsidies to schools may enable these institutions to employ more faculty members, they provide no means for the development of teachers and investigators to fill these added positions. No thought appears to have been given to the training of students for careers in the preclinical sciences, anatomy, physiology, biochemistry, etc., essential to the conduct of a school of medicine. Internships and residentships have been mentioned, but consideration has not been given to means by which young graduates may afford to prolong their education to this extent, and by which hospitals may be enabled and encouraged to increase the educational advantages of these positions. Post-doctorate training has been entirely neglected.

The need for a subsidy of $2,400 for each student in excess of present enrollment in schools of public health seems neither necessary nor desirable, since present enrollment in most, if not all, schools of public health is not up to the capacity of these schools. More funds are needed for fellowships for students in public health, especially to provide for students who are not sent to school by official public health agencies. Additional funds are also urgently needed to strengthen teaching and research in schools of public health.

Appropriations.—Student enrollment is probably the most practical criterion for initial allocation of funds to schools for general educational purposes. The schedule of appropriations established must be considered as an experimental emergency or pump-priming proposition for a term of 3 years. During this term studies are to be conducted by the Surgeon General to establish principles on which a continuing program of educational support may be based. Such an experimental approach to the problem appears to be sound. Whether the particular figures mentioned in the bill for each category are appropriate is beyond the competence of the authors to decide. Presumably they have been selected after due consultation with expert authorities. It is to be hoped that this subject will be thoroughly searched in these hearings in an open-minded effort to arrive at the proper sums.

Funds for construction and improvement of buildings and facilities are obviously essential supplements to the subsidies for general educational purposes. They cannot, however, be allocated on the same simple principle, in proportion to student enrollment. It would be possible, and perhaps wiser, however, to appropriate specific amounts for an initial experimental term to be revised when a proper formula can be devised on the basis of experience. Well-conceived long-term planning, highly desirable in such an educational program, should not be exposed to the hazards of annual appropriations.

The same criticism applies to the indefinite formula for appropriations for scholarships. Target figures for a preliminary period could be developed in these hearings, either in terms of cash sums or numbers of scholarships.

Conditions of grants.—It is stipulated that in their respective roles States and institutions must file plans in order to become eligible for grants. The specifications for these plans are, however, of a regulatory nature designed to prevent abuses, guaranties rather than plans. Something more constructive is highly desirable, especially if, as its presence in this bill implies, this educational title is a component of a general health program. The authors suggest as did the Committee of Physicians for the Improvement of Medical Care in its remarks about S. 2588: "In order that the public may be properly protected against misuse of its funds and in order that quality of performance may be fostered in the educational program, each eligible school seeking grants should be required to submit to the Surgeon General a prospectus consisting of (*a*) an assessment of its resources in funds, buildings, facilities, and personnel, and their apportionment to educational, research, and service functions; (*b*) a statement of the educational needs of the institution; (*c*) a plan to meet these needs, with priorities specified; (*d*) a statement of the number of students presently enrolled and the number that could be accommodated if funds required for expansion were obtained. Provision should be made that such prospectuses could be revised annually. Such prospectuses would be subject to verification and approval by the Surgeon General with the approval of the council.

"On the basis of these approved prospectuses and of principles devised by the council with the aid of expert advice from its committees and individual consultants, the funds appropriated could be allocated among the eligible schools with consideration, in the order mentioned, of (*a*) the preservation and improvement of the quality of education; (*b*) the enlargement of the number of physicians; (*c*) the relative need of schools; and (*d*) the desirability of geographical dispersion of medical resources."

The formula for determining the eligibility of schools, though vesting authority in the Surgeon General after consultation with the council, implies that this prerogative may be delegated to private organizations or bodies which are not an integral part of the administrative structure of the title nor responsible to this administration. Although the advice, factual information, and recommendations of such bodies may, and probably should, be utilized, the phraseology should be so altered that ultimate authority and responsibility is inalienably vested in the hands of duly appointed officers of the Government.

Since this is a national program supported by Federal funds, injunctions against the exclusion by a State of nonresidents is quite justifiable. The antidiscrimination clause seems intended to open the door to equal educational opportunity for all groups of the population without excluding from the benefits of the title those States, communities, or institutions which have restrictive laws, regulations, or customs. Though in theory health may be separable from civil rights, in practice the health of a community is indivisible. The avowed purpose of this title is, by the support of education, to improve the health of all the people of the Nation, with especial attention to the relative need of segments of the population. If there must be a compromise on the subject of discrimination at this time, therefore, it should be so phrased that this objective is not sacrificed. The last part of this clause leaves so much discretion to the Surgeon General that the whole purpose of the clause might be defeated. Even without such sweeping discretionary provisions experience to date has shown that equal educational opportunity, at the postgraduate level, at least, has not been achieved by the requirement that comparable opportunities be granted for members of excluded groups.

Enlargement of the personnel of a medical school would be useless if physical facilities were not also expanded. This expansion properly includes hospitals. It wisely provides that though these need not be part of the State plan for general hospital construction and will be financed separately, they must conform to the regulations prescribed under the State plan.

Scholarship aid is limited entirely to students in the regular medical school course. In the selection of men for such aid consideration is given only to population and local need. These are among the numerous indications that these scholarships are intended primarily not to improve the quality of physicians, but as inducements to these trainees to equalize the distribution of physicians. The conditions imposed on the States are, on the whole, well devised to prevent abuses. The qualifications for the selection of appointees, "on the basis of ability and such fatcors as the State may find necessary and reasonable to carry out the purposes of this part," however, allow too much freedom of interpretation. If ability is to be the prime quality, as it should be, it should be impossible to dilute or eliminate it. If exceptions to this standard are to be permitted on the basis of distribution of appointees according to population, area, need, or for other valid reasons these should be specified. But, within any category ability alone should be the criterion. Since this term is not qualified by any such adjective as scholastic, it permits ample latitude. The clause in S. 2588, "for ability or such other factors as may be permitted in regulations," though too lose, is preferable to the present clause.

No objections can be raised to the purely regulatory conditions imposed upon applicants; but the condition that an appointee must agree, in return, for each year in which he received scholarship aid, to devote one-half a year to professional service under a Federal or State agency or in some area designated because it lacks adequate medical services, is peculiarly ill-advised. To quote the remarks of the Committee of Physicians for the Improvement of Medical Care concerning a similar provision in S. 2588: "No assurance is given that adequate facilities or remuneration of any kind will be given for these services. From the standpoint of public interest, to sacrifice physicians, selected for special aptitude and exceptionally trained, in this manner at the moment when they most require experience and the opportunity to exercise their talents in the most favorable environment would be deplorable. From the standpoint of medical schools it would be a poor investment. No wise applicant with exceptional talent would embark on such a speculative course. The proper way to secure physicians for Government agencies and rural areas is to make these services attractive by providing facilities, careers and security in them." The present scholarship provision will remove one of the chief inducements to such improvements, the need to attract physicians.

Medical education does not end with the formal medical school course. At least 1 year of internship is required and, if a physician has any ambition to a career of distinction, this must be supplemented by one or more years of residentship or fellowship. For internship or residentship in the best teaching hospitals, remuneration is restricted to subsistence, sometimes supplemented by a token cash payment. Scholarship aid through medical school will be of limited benefit if the appointee is unable to enjoy the advantages of a subsequent internship, at least. Scholarships for this purpose would be an excellent investment. We suggest that each medical scholar who completes his medical school course with a satisfactory grade should be granted a subsistence wage (e. g., $50 to $100 monthly) during an internship of 1 year in a hospital of his choice which meets certain qualifications as a teaching institution, agrees to accept the applicant and to deprive him of none of the privileges or emoluments accorded to other interns (in order to protect the intern from diversion of his scholarship to costs usually borne by the hospital).

There is a crying need for fellowships or scholarships for the extension of training beyond the internship, to enable especially gifted persons to prolong their education, in an effort to develop persons who will strengthen the educational system and contribute to the advance of medical science. Such scholarships should be granted for 1 year with the opportunity for renewal for a limited term of years. The number of scholarships available for each successive year should diminish, while the remuneration (which should be generous) should increase. Although the incumbents should not be prohibited from investigative activities, the chief object of these scholarships should be to enable men to continue their education, engage in clinical activities, and aid in the education of their younger fellows. They should, therefore, be assured of appropriate positions (residentships, instructorships, etc.). They should not be prohibited from accepting for an interval in their careers research fellowships. These scholarships should be open to all who have proper qualifications; no one should be guaranteed continuity in the position of a scholarship. Such a program would be an invaluable aid to clinical teaching and would naturally link with the general educational program.

Administration.—The United States Public Health Service is the body best equipped for the administration of any program dealing with health. If, however, this Service is to assume the additional administrative burden that this program will involve, some provision should be made in the bill for the added administrative expenses. Under the present organization of Federal offices health services are subordinate to the Federal Security Administrator and acts of the United States Public Health Service are ipso facto subject to his approval.

The present bill provides for a National Council on Education for Health Professions, composed of 4 ex officio members from governmental agencies and 20 civilian members representative of medical and educational groups and the public. The civilian members are to serve without remuneration for staggered terms of 4 years. There is no obvious reason why governmental agencies should have special representation on an advisory council which deals with the support of medical education. A council of the proposed composition would rightly arouse fears of bureaucracy. The four governmental employes, being always present and specifically delegated, would be at an advantage over the volunteer civilian members. Each one of them would have a special personal interest to serve. Such agencies should be given the right to appear before an advisory council of civilians. Moreover, each one of these agencies has the right to petition Congress for appropriations to meet its needs. The United States Public Health Service has ample experience in awarding fellowships and has established exemplary machinery for this purpose. Members of the advisory council appointed under such a program should be remunerated for expenses of travel and subsistence and for services while engaged in work of the councils outside of their residences. Necessary funds should be granted for the costs of administration.

Noninterference.—The proviso against interference with the autonomy of medical schools is an essential feature to allay fear and criticism. Better assurance against interference will come from such careful drafting of the measure that noninterference is implicit in its terms.

Part B—Practical-nurse training

The need for the services of competent nurses with less educational background and training than are required for registered nurses is becoming continually more apparent. Nurses with degrees or diplomas from the best university or hospital nursing schools are more and more in demand for administrative of educational positions which offer them opportunities for advancement and careers. Competition with nursing schools for women with aspirations for services in the fields of medicine and health has created by medical schools, schools of public health, and social service. The number of trained nurses who are willing to devote themselves to the personal offices of nursing, especially in homes, with the restrictions and lack of opportunity for advancement which this occupation involves is steadily diminishing. Efforts to revive the old pattern have been unsuccessful. Even if the enrollment of nurses in present schools could be greatly expanded it is doubtful whether it would aid in solving the problem. This has prompted the search for a solution through the training of practical nurses with less exacting requirements. The present program appears to be frankly experimental. The appropriations proposed are moderate. The conditions for grants seem to be drawn with sufficient care to prevent abuses, without unduly limiting the opportunity for play of ideas and variation of method that is essential for the experimental approach.

TITLE II. MEDICAL RESEARCH

This must properly be considered as part of the educational provisions. It proposes to extend the existing program of research in the Public Health Service by adding more special institutes for the investigation of additional diseases. It is to be entirely devoted to project work.

There are several objections to such an ad hoc approach to the solution of medical problems. The returns from directed investigation on the whole are apt to be small in proportion to outlay. The chief value of such concerted efforts lies in the practical elaboration or exploitation of fundamental discoveries. The fundamental discoveries upon which these discoveries depend are usually the product of individual curiosity and the alert intuition of trained minds. Projects are too likely to accumulate mediocre persons who multiply data. The independent investigator with imagination and brilliant ideas cannot be diverted from his spontaneous interests. Efforts to direct his activities into other channels may only dry up his inspiration. The categorical approach to the solution of medical problems has inherent defects. Diseases—and especially the types of chronic disorders mentioned in this bill—cannot be investigated in vacuo. They do not exist independently of one another nor apart from the subjects whom they afflict. The evils of the system increase as the number of segregated compartments is multiplied. From the educational point of view such segregation is peculiarly undesirable. Projects do not afford opportunities for fundamental training nor for the development of initiative and originality in younger men. They force teaching departments which accept them to divert their activities from natural to expedient channels.

Somewhere in a national health program provision should be made for the development of teachers and investigators. Without such provisions neither educational nor research programs can achieve their full value. A formula should be found by which support can be given to the integral structure of teaching departments of medical schools and to permit the most capable young physicians to prolong careers of investigation and teaching. Funds should be made available to the most capable men in these schools, not to divert them from their spontaneous interests and pursuits, but to support them in these activities.

This opinion implies no aspersions upon the existing program of grants for investigation made through the United States Public Health Service. These grants have been invaluable and the United States Public Health Service is to be congratulated upon the intelligent and responsible manner in which the programs have been conducted. It would be unfortunate if they were not permitted to grow in a healthy evolutionary manner.

TITLE III. HOSPITAL SURVEY AND CONSTRUCTION AMENDMENT

There is general agreement on the need for expansion of the hospital construction program. With the institution of a system of general medical care for the Nation this need will become the more urgent. The lack of adequate facilities is one of the features that will limit the immediate practical operation of such a program. On the other hand, the public at large will be unable to support or utilize adequate facilities unless they are enabled through a comprehensive program to meet the costs of general medical care. There is already a body of experience on which to draw for the expansion of hospital construction. The present legislation appears to have given this consideration. The provisions seem to have been conceived in a liberal spirit, leaving room for experiment with adequate safeguards against abuse. Especially gratifying is the inclusion of group practice and cooperative units and provisions for subsidized experiments in the regional coordination of facilities.

TITLE IV. SPECIAL AID FOR RURAL AND OTHER SHORTAGE AREAS

Part A of this title proposes by subsidies and loans to attract personnel to rural areas, by assuring adequate income and facilities. Part B is for the promotion of experimental projects of a special nature, cooperative organizations for the provisions of medical care. Both are evidently intended to accelerate the development and distribution of the personnel and facilities required to put a general medical program into effect on a Nation-wide scale.

Such measures, and especially those of part A, are useful and necessary expedients to meet an urgent situation. They appear, however, to be predicated upon the premise that rural areas can and should be medically self-sufficient. With the growing complexity of medicine this is not likely to be possible, even if it were desirable. It would be most uneconomical for thinly populated areas to attempt to support the resources necessary to provide complete medical care; it would be impossible for such areas to utilize to capacity such resources. There should be provision, therefore, for broader experiments in the regional organization and coordination of medical facilities and personnel.

TITLE V. GRANTS TO STATES FOR STATE AND LOCAL HEALTH WORK

The chief objectives of this bill are similar to those of S. 522. The present title is, however, far more sweeping in character and more vaguely drawn. S. 522 was directed first and foremost to the establishment of basic full-time health services in this country under standards that would make them economically feasible and functionally effective. The need for such services has been demonstrated. There is a wealth of experiment and experience in the institution and conduct of such services. The conditions for grants in S. 522 were so prescribed that this experience would be used without limiting further experiment. It did not promote the extension of the functions of public health into new fields nor did it enjoin such extension. The present measure, while it provides grants for extension of basic health services, omits all definition of the nature of these services and specifications that would insure quality and responsibility. On the other hand, it includes in public health services not only the prevention and control but also the treatment of a long list of diseases to which the Surgeon General may add as he pleases. There is no clear reason why the Surgeon General, under the terms of this title. should not take over the whole practice of medicine, although this is presumably not the intention of the title.

Although under title VII, administration of the medical-care program is entrusted to the Surgeon General, there is nothing in that title to suggest that general medical care will be provided by public health services. Certain medical-care functions—e. g. tuberculosis, venereal disease, and mental disease—have, for reasons of public interest and protection, been conceded to the public health services. It may prove necessary in the future to adopt a similar policy toward other diseases; but on the whole, the categorical treatment of disease violates the best principles of medical care which require that patients be treated as a whole, not in parts, as individuals who may have a variety of diseases or disorders, not merely as hosts of a particular ailment. A national health program should aim at the closer integration of public health and medical services. This will ultimately tend to break down the barriers between the two and to shift the allocation of functions between them. This cannot be advantageously accomplished by directive at the present time. Medicine and public health have developed along separate channels that fit neither to assume the functions of the other.

The authors wish to express approval of S. 522 and recommend that title V be altered to conform to the principles of that bill.

TITLE VI. RESEARCH IN CHILD LIFE AND GRANTS TO STATES FOR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

Part A, with its indefinite objectives, does not seem relevant to a health program. It would be more appropriate in an educational program. If it were properly organized and oriented, it would undoubtedly serve a useful social purpose. There are, however, distinct dangers in loading a program directed to a specific end with functions not directly correlated with this end. This part amounts to a rider on this bill. Experience has shown that the passage of even desirable measures by inappropriate means, and their allocation to unsuitable agencies, leads to a fractional administration that is inefficient. This moment, when efforts are being made to rectify errors of this nature, committed in the past, is not the time to add to these errors.

Part B.—Concerning this part we can only repeat what the Committee of Physicians for the Improvement of Medical Care has said of similar proposals in previous health bills. The present bill proposes to establish a comprehensive program to provide medical care for the population as a whole on the principle of contributory insurance. In this title, however, a particular segment of the population is set apart for special treatment with entirely separate financial and administrative arrangements. In the absence of a comprehensive program special provisions for the protection of women during pregnancy, and for children were highly desirable. But with the establishment of a comprehensive program it becomes not only unnecessary, but undesirable, to segregate different branches of medical care. The state of pregnancy is not separable from the pregnant woman; the perils of childbirth are not independent of the general health of this woman. The ages of 18 and 21 prescribed in the two programs of this part do not mark the recognized lines between pediatrics and adult medicine. Children, as thus defined, do not comprise a medically homogeneous group. Many of these children will be employed persons eligible for insurance benefits in their own rights.

No one can deny the desirability of insuring to the coming generation a greater measure of health than its predecessors have enjoyed. To this end the contributions of the Children's Bureau have been of inestimable value. They have set a pattern in their fields for a national health program. The services of this organization should be retained, but, as far as health services are concerned, they should be integrated with the program as a whole.

It is conceivable that the burden of the costs of maternity care and the care of dependent children cannot be adequately supported by contributory insurance alone, but will require tax support. If supplementary tax funds are required for these or other purposes in order to assure the success of the comprehensive program they should be included in the general provisions of the bill, in order that they may be applied to the purposes for which they are most needed.

Whereas in other titles the composition and functions of advisory councils are prescribed, in part B of this title these matters are left entirely to the discretion of the Administrator, who is not even required to consult the council and commitee he is authorized to appoint.

TITLE VII. PREPAID PERSONAL HEALTH INSURANCE BENEFITS

Again the bill separates the medical provisions of the general medical-care program from the social and financial provisions which are intended to put it into effect. However, appropriations and provisions of the bill are linked with wages and with social legislation needed to implement the bill. The title follows the terms of S. 1320, presented in 1947, almost verbatim in most respects. The most important change is the increase of taxable wages from $3,600 to $4,800, which was made to meet the increase of costs. Provision is made to supplement the income from insurance premiums with Government contributions and to permit groups who are not directly eligible for insurance, including the needy, to receive the benefits of the medical-care system established for employed persons, if arrangements are made for payment of their contributions through agencies of the State or local governments.

Purpose

We again wish to express our sympathy with the principles and purposes of the title and the earnest efforts that its authors have made to meet constructive criticism and adapt the measure to shifting medical and economic conditions.

Coverage

To provide at once comprehensive health services to all or nearly all the people is a task beyond the presently available resources and personnel of the country. There is a large body of experience and experiments on a smaller scale to guide the program, and freedom is given in the bill to further experiments. It has become evident that large-scale experiments are necessary for the development of a comprehensive program. History teaches that action rarely anticipates, but usually follows need. A long time has elapsed since the need for a national health program became evident. A war has intervened. It may be seriously questioned whether we have become better equipped in resources for such a program in this interval. A dilatory course cannot be continued indefinitely.

Stepwise programs have been proposed. These are of two kinds: One would confine attention initially to a particular economic group of the population. These measures will be considered separately in connection with other legislative proposals. The second would restrict initial efforts to single classes of patients, drawing distinctions on the basis of age or types of disease. It is natural that the strongest advocates of this approach should belong to those interested in the particular aspect of medical care for which they seek priority. Nor is it surprising that their proposals should arouse opposition and suspicion among those whose interests lie in other fields of medicine to which they attach equal importance. We believe that the aim of a national health program should be to escape from the categorical approach to medical care, to work toward a correlated system. Preferential treatment of one branch of medical care will not necessarily aid in the preparation for such a comprehensive system. It might even hinder such preparation by diverting personnel and resources into a single channel that offered superior opportunity. It would tend to produce an unbalanced system and one that might prove unhappily weighted. There can be no certainty that present values and categories will prove permanently the best. Room should be left for the freest competitive experimentation in evolutionary development. There is no reason why, within the framework of a comprehensive program, such experimentation in the provision of exemplary care should not be undertaken by any branch or group of the medical profession. Such experimentation should be facilitated by greater freedom from financial anxiety and insecurity.

If broad coverage is contemplated it is inequitable to except from the program small groups or fractions of the population. It is gratifying to note that in each successive version of the bill means have been found to include more of these fractions. Among these have been civilian Federal employees. It is regrettable that employees of the State and local governments cannot likewise be included unconditionally. Most important in this respect is the provision that enables the needy through arrangements by the States with Federal aid to enjoy the benefits of the services to which insured persons are eligible. Under a dual program individuals in the marginal income group would be continually shifting between the two systems of medical care. To quote from the Committee of Physicians for the Improvement of Medical Care, Statement No. 22: "If States wish to continue to distinguish between needy and employed persons with respect to medical services, they cannot well be denied the privilege, but such a distinction is as inappropriate in a national health program as it would be in a system of public education."

Financial

Although the basic premium rate of 3 percent of earnings is retained, the maximum limit of earnings upon which this shall be assessed has been increased from $3,600 to $4,800, to meet increased costs. Some increase there would have to be if the quality of anticipated service is not to be allowed to deteriorate. Presumably the increase is based on actuarial estimates. Provision has, however, been made, as it was in the last bill, for supplemental Government contributions if these should prove necessary. Part of these contributions are to be used in an effort to add dental and home-nursing benefits, for which present resources are admittedly inadequate. Additional supplements for unrestricted purposes are authorized. Such latitude is essential for the initiation of a program of this magnitude, the costs of which cannot be accurately predicted. A temporary limit for over-all appropriations of 4 percent of earnings has been set for the first 6 years, at the end of which time a review and reevaluation of the system must be made to serve as a basis for further financial arrangements. On the whole these provisions seem soundly conceived.

Provisions that funds must be allocated among the five classes of personal health services and that allocations once made cannot be diverted from one class to another is of the greatest importance. It assures competitive equality in service and prevents exploitation of one class by another, the cheapening of one service for the benefit of another.

Administration

These parts are identical with those of the preceding bill, S. 1320.

Federal.—If the complicated administrative structure proposed in this bill is to achieve its purpose, the allocation of responsibility between the authorities at different levels must be planned with great wisdom and will require revision with experience. Fears of overcentralization and bureaucracy must be balanced against dangers of too great dispersion and the multiplication of personnel and overhead costs which this may entail.

Consolidation of ultimate executive authority in the hands of a Presidential appointee, the Federal Security Commissioner, is in line with established precedents. It links accountability with responsibility. The composition of the proposed National Health Insurance Board was apparently devised to allay fears of dictatorial control by a single head, the Surgeon General of the United States Public Health Service. It violates, however, the very principle so carefully preserved in the ultimate authority, the conjunction of accountability and responsibility. This Board contains two ex officio members, the Surgeon General of the Public Health Service and the Commissioner for Social Security, who will also serve as the effective administrators or executives of the program. Since they will be charged with the promotion of certain practical objectives which are the chief concern of the Board, they will be suitors to the body on which they are serving as advisers. These ex officio members would be at a great advantage over the three appointed members because their duties on the Board would be part of the functions of their offices. On the other hand, they could escape accountability for improper conduct because of their concealed positions on the Board. We believe that a single appointed administrator (or a professional administrator, the Surgeon General, and a financial administrator, the Commissioner for Social Security), supported by an expert advisory council or councils which cannot be short-circuited nor circumvented, will be more efficient and more responsive than the Board proposed in this bill.

In this case it might be necessary to provide separate advisory councils for the two heads as previous bills did. The general composition of the advisory council proposed in this bill is well balanced. A similar formula would be suitable if the administrative authority were altered to conform to the recommendations made above. Care has been taken to compel the board to consult the council and to give due publicity to its recommendations, to assure reasonable consideration of these recommendations. There is a certain incongruity in a council advisory to a board which has advisory functions of its own. If an administrative board is established, it might be more appropriate to implement it with the kinds of expert committees which the council is empowered to establish.

State.—The requirements of State plans and the principles governing the character of these plans have been so formulated as to assure the observance of the general aims of the program, to protect Federal funds from misuse, and to facilitate over-all administration without stereotyping services. The provision that the Federal authority may put the program into effect in a State that is dilatory in the preparation of a plan seems ill-advised. It gives grounds for fears of Federal interference in the autonomy of States and localities. It was introduced not with this intention, but on the plea that it would be an injustice to deprive the people of the State of benefits for which they would be paying. These people are not, however, deprived of the power to correct this injustice. It may be anticipated that they will compel their States to prepare plans and apply for participation in the health program if the injustice seems to them onerous.

Local.—Among the conditions imposed upon the State plans is the establishment throughout the State of local health-service areas which will serve as the ultimate administrative units of the plan. Those areas are permitted to elect either one of two types of agencies: (1) An administrative committee with an executive officer or (2) an appointed administrative officer with an advisory committee. The first type of agency is open to the same objection advanced against the National Health Insurance Board in the Federal structure. Responsibility and accountability will be dispersed and concealed. Whereas at the Federal level a board of only five members is proposed, these local committees are to be composed of from 8 to 16 members. A body of this size is ill-suited to administrative functions. Its members will presumably be unpaid, serving on a part-time basis. The committee will of necessity be obliged to serve chiefly in an advisory and consultatory capacity. The executive officer will be forced to perform the actual administrative functions, which will frequently be of such urgent character that they cannot wait for the action of so clumsy a committee. If, by chance, the members of the committee are negligent or preoccupied with their more personal interests, the executive officer will be altogether unrestrained. In point of fact, the two types of agencies are likely to differ in only one respect: the administrative officer can be held accountable for his errors, the executive officer can escape accountability. In both instances the persons responsible for administration are to be appointed by the State agency, which may be expected to exercise no less judgment in the selection of an administrative officer than in the selection of members of an administrative committee. We favor retaining only one type of agency: an administrative officer with an advisory committee. The functions prescribed for these agencies appear to be satisfactory.

Benefits

The health-service benefits, the same as those offered by previous bills, are truly comprehensive. The restriction placed upon drugs, though necessary, is unfortunate. It is to be hoped that eventually some formula may be found by which drugs may be included with the abuses which are rightly feared would follow their immediate general inclusion. The inclusion of unusually expensive drugs, under regulations established by the Board, removes the most serious evils of this restriction. The temporary limitations placed upon dental, home-nursing, and auxiliary services are merely a recognition of the present serious deficiency of personnel and facilities.

Free choice with respect to all types of services is guaranteed to beneficiaries. The provision that access to services other than those of general practitioners, including services of specialists, must be secured by reference through a practitioner or administrative medical officer is essential to prevent self-diagnosis and unnecessary use of more costly services. Protection against delay in obtaining needed care is assured by exception of emergencies.

Participation of persons in service

Any person can furnish, under the terms of the bill, services which he is legally qualified, under State laws, to furnish, provided he agrees to participate in the program and to abide by the regulations established for the conduct of the program. Where there are no State regulations, the Board is empowered to establish standards and regulations for qualification. Such a provision is not only desirable but essential as a safeguard against gross inequalities in the quality of services in the various States and the expenditure of Federal funds on inferior services in States that maintain no standards.

Groups of various kinds, including hospitals or hospitals and their staffs, will be utilized. In addition to these operative groups, voluntary health-service insurance agencies, whether or not they enter into agreements with the State agency on their own behalf, are also permitted to act as agents for individuals or persons for rendering personal health services under the program. The individuals or persons who actually furnish the services must however, have entered into agreements with the State agency. Private insurance agencies are not required for a compulsory system with almost universal coverage. Such intermediaries between the Government and the beneficiaries can only increase administrative costs. There is a proper place for these agencies in the provision of extra service.

Methods of payments for service

These are the same as those in S. 1320.

The majority of general practitioners in a local health-service area may elect the method of payment for practitioners' services that shall prevail in that area: fee-for service, per capita or salary. Opportunity shall be given, however, to members of the minority to practice under the methods of payment they may prefer. These privileges, in previous bills, were unconditional. In the present bill they need be granted, however, only when it is found that such alternative method contributes to carrying out the provisions of section 235 (which declares the principles of the program) or otherwise promotes efficiency and economy. We are opposed to the inclusion of the fee-for-service method of payment for practitioners. To quote from the committee of physicians for the Improvement of Medical Care (Statement No. 5): "The fee-for-service method does not foster cooperative procedures which promote the utilization of consultant and specialist services, diagnostic and therapeutic facilities, and educational contacts. In addition, experience has shown that it may lead to malingering on the part of patients and to promongation or exaggeration of illness on the part of physicians." The method of remuneration of the family physician should be so devised that it centers his attention upon health rather than illness. Remuneration on a per capita basis has this effect; remuneration by fee-for-service makes income dependent on illness rather than health. Under the per capita system of payment, the practitioner's income does not suffer by ready referral of patients to specialists. Under fee-for-service remuneration, such referral may deprive the family physician of the fee that he might receive by caring for the patient himself. The fee-for-service method of payment, therefore, tends to promote competition, not cooperation, between practitioners and specialists. We admit that if, because of the pressure of organized medicine and the uniformed state of public opinion, it could not be excluded, a compromise that established competition between individual practitioners, groups, and hospital organizations on fee-for-service or other bases of payments could be accepted, because it would establish competition in which the relative virtues of various methods of payment could be tested. The proviso in the present bill removes assurance of such competition. The terms in the last bill are to be preferred. The word "contributes" in the present bill is peculiarly unfortunate because it is too broad and indefinite, a subject of opinion. If the previous formula cannot be restored, we at least recommend that the words "contributes to carrying out" be deleted and that the words "is consistent with" be substituted for them.

In provisions for payment to specialists, the words "or other basis" convey no meaning. If they are retained, all other specifications may as well be omitted. They are used with respect to no other class of service.

In a period of economic flux it is realistic to leave unspecified the actual amounts of payments to hospitals. The bill provides for payment on the basis of the reasonable costs of hospitalization benefits. It would be advisable to substitute for the words "reasonable costs" the phrase "costs reimbursable upon the basis of accepted cost-accounting systems." Obviously, there must be standards for comparison on which maximum rates will have to be established.

The provision for prorating, among practitioners furnishing services on a per capita basis, payments with respect to unallocated individuals seems a happy solution for a highly controversial problem.

The special provisions for rural areas offer an experimental approach to the solution of the problem of distribution of physicians and means for furnishing service in thinly settled areas.

Amount of payment

The principles on which rates are to be fixed have been thoughtfully prescribed with careful attention to equity, economy, and efficiency. Especially important is the provision that equivalent services must be equally rewarded under all methods of payment. Only if this principle is observed will the best method be ascertained through experiment and competition. The provision against overloading of physicians is commendable in principle, but discretion will be required in its administration lest it be used to expand the clientele of the inferior and incompetent physicians of an area at the expense of the superior and competent.

The provision for equalization of payments under agreements with groups and other organizations is also gratifying. It should be specified that this refers not only to operating groups but also to intermediaries such as private voluntary insurance agencies, to administrative costs as well as costs of services. Objections to the inclusion of such intermediaries would be removed if their participation were contingent upon proof that they did not add to the expenses of the program nor detract from the rewards of those who actually furnish services.

Like the other provisions, this one gives no consideration to the fundamental need for basic education and the development of the educational system itself. This is taken for granted. Attention has been given only to the training of personnel for technical purposes, in a presumable attempt to meet an immediate urgent deficiency. Education cannot be developed soundly on a purely expedient policy. The measure is framed for a long future in terms that look only to the immediate emergency. One of the most serious causes of the present deficiency is the fact that throughout the war educational efforts were diverted too much to the mere training of personnel. This tends to sap education at its roots, preventing its growth and reproduction. To prolong this policy would be deplorable.

General conclusions

With the general intent and purposes of this bill, we are in hearty sympathy. Title VII, which is the core of the comprehensive program, shows the most careful draftmanship, the product of long years of evolution. We approve the passage of this title with the modifications suggested. The preceding titles appear to have been introduced for opportune purposes and without sufficient consideration of their relation to the program as a whole. The educational and research provisions of title I, II, and VII should be consolidated and reframed, as indicated in the discussion, into an integrated program that will improve the quality as well as increase the quantity and distribution of personnel. The hospital-survey and construction amendments (title III) are satisfactory and essential. Special aid for rural and other shortage areas (title IV) was previously included in the general program. Since the provisions of this title may be regarded as largely temporary and experimental in character, their separation from the more general and permanent provisions may be justified; but, if they are essential to the success of these general provisions, such separation may jeopardize their passage and thus compromise the program. Title V is especially open to criticism. It is so phrased that the fundamental need of full-time health services will not be assured, and so sweeping that it seems intended not to complement but to duplicate or compete with the provisions of title VII. Part A of title VI is not altogether relevant to a health program. Part B should be drawn so that it is integrated with title VII. Children and pregnant women are people. Although those criticisms are numerous and not unimportant, they deal chiefly with matters of emphasis and organization, rather than principle. They do not constitute insuperable objections to the bill. No one of the titles can be deemed superfluous. We hope our criticisms will be given studied consideration to the end that the proposed comprehensive health program may be launched with a minimum of initial handicaps.

Professional rights and responsibilities

This section, which affirms existing laws and usages, is satisfactory.

Confidential information: Nondiscrimination

We heartily approve the intent of this section.

Complaints, hearings, etc.

Adequate protection has been given to these sections for judicial prevention of abuses and protection of individuals against injustice.

Grants-in-aid for training and education

In previous bills, provisions for education and research of a general nature as well as for professional training have been incorporated in the health-insurance program and have been made a charge upon the insurance fund. In S. 1320, an amount equal to 2 percent of the expenditures for benefits was authorized to be used for these purposes after the first 2 years.

The present bill contains a similar section, but in this provision is made only for the training of professional, technical, and administrative personnel for utilitarian purposes connected with the provision of personal health-service benefits. The maximum amount to be expended for these purposes has been reduced to ½ percent of benefits. Evidently, the separate provisions for education and research in titles I and II are intended to replace part of the educational and research program previously incorporated in the health-insurance program. To subdivide the educational program seems most unfortunate, especially when provisions are so framed that the different parts cannot be administered as a unit. One of the greatest virtues of a comprehensive health program is the opportunity it will give for the integration of all the contributory services, among which education should hold a prominent place.

COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC,
April 1949.

STATEMENT NO. 27

Senate bill S. 2588—introduced by Mr. Thomas of Utah April 30 (legislative day, April 22), 1948

DISCUSSION AND RECOMMENDATION OF THE COMMITTEE OF PHYSICIANS FOR THE IMPROVEMENT OF MEDICAL CARE, INC.

THE NEED FOR FEDERAL SUBSIDIES FOR MEDICAL EDUCATION

Medical education has become the longest, most arduous and most expensive form of education. It is expensive both for the students and for the medical schools. To qualify for the practice of medicine through any of the best schools in this country it is necessary to complete a college course or its equivalent, including certain prescribed disciplines. This must be followed by 4 years of arduous work in the medical school. In addition to this, at least 1 year of internship is almost obligatory. If the applicant desires to distinguish himself in any way he is forced to spend from one to five further years as resident. Only a variable part of the time of these years of internship and residency can be actually devoted to educational activities, the remainder—often the major part—is spent on service to the sick and to the physicians of the community. Actually interns and residents are apprentices in medicine. In other walks of life they would receive remuneration for their service functions. Because of the eleemosynary nature of these services and the nonprofit status of the institutions within which they are conducted, however, there is no source from which such remuneration may be derived. At the best, men in these positions receive a subsistence wage. It is tacitly implied that the training they acquire is sufficient reward for their services. The future returns they may anticipate as a result of this superior education do not, however, enable them to meet the present costs of the educational investment.

The medical school for its part must provide in the preclinical years a curriculum which requires peculiarly and increasingly costly facilities. These are, however, paltry compared with those required in the clinical years which include not only facilities for the care of patients but also a variable proportion of the costs of this care. These are, like the service functions of interns and residents, a valuable contribution to the welfare of the community and should not properly be borne on the shoulders of education. As the practice of medicine and hospitals have evolved in this country, however, there is no immediate means by which education can be relieved of this burden.

The equipment and facilities required for the proper practice and teaching of medicine are steadily increasing in number and cost. The effectiveness of medicine, if these facilities can be made available, has probably increased in greater proportion than the costs, but means to defray the costs have lagged behind. When medical education consisted chiefly of didactic courses, medical care was personal ministrations, and hospital care was limited to the provision of bed and board, the philanthropy of physicians and generous individuals, with public aid for the indigent could provide medical care. This is, however, no longer practicable, as both the value and the cost of medical care have been greatly enhanced.

Although tuition fees have risen at a staggering rate in recent years, they are falling steadily shorter of meeting the costs of tuition. To raise them further would eliminate all but the wealthy from our medical schools. It would also tend to curtail the educational careers of the less wealthy when educational requirements are increasing, thereby debasing the quality of practice. These tendencies might already be evident were it not that a large proportion of students are aided by GI rights. What may happen when this support is removed is unpredictable; but it is reasonable to suspect that present tuition rates will divert many superior aspirants from medical careers. As costs rise it is becoming increasingly difficult for physicians to continue to contribute gratuitous care or avocational teaching, upon which medical schools have had to depend for most of their clinical instruction. Moreover, if time is divided between competitive practice, gratuitous care and avocational teaching, the two latter must suffer and little time can be devoted to the self-education of the teacher, which assumes even greater importance as the advance of medicine is accelerated by science. That philanthropy will not, if it could, assume the burden is amply demonstrated. Philanthropic funds can be secured for projects having definite objectives, but not for continuing public service. Moreover, philanthropy cannot be organized or directed for such purposes. Industry cannot properly contribute except insofar as its contributions further its own particular ends. At least that part of medical education which directly contributes to the collective welfare of the members of the community is a proper charge upon the community. Because this service function is inherent in and inseparable from medical education, medical education is a more definite responsibility of the public than any other kind of higher education. Although this position derives from the inherent service function, the public would be ill-advised to confine its support to this function alone, to the neglect of the remaining body of the medical educational system from which it is inseparable.

States and local communities are incapable of assuming full responsibility for the support of our educational institutions. Many of our States have not the necessary resources, if they had the taxing powers. Moreover, if our schools became dependent upon such local resources, pressure might be brought upon them to limit their enrollment to members of the localities that supported them. This would tend to multiply inferior schools because it would tempt States with inadequate means to establish such institutions to meet their needs. It would also tend to provincialize medical education, a most undesirable thing. Communities and States should assume the full measure of their proper responsibilities for the care of public charges and community health services. They should contribute to medical education as many of them have in the past. But their efforts should be supplemented by the Federal Government because it has the necessary taxing powers and is in a position to organize educational aid in a broad and comprehensive manner that would assure fluidity, exchanges of personnel and competitive selection with a large field for careers that would attract superior men. This does not imply any limitation of competition or variety on the part of individual institutions. Formulas have been devised by which qualifications that assure the responsible use of Federal funds can be combined with the greatest freedom in the purposes for which these funds are used. Boards of research grants and fellowships from the United States Public Health Service have established a record for the finest discrimination and for the development of personnel and the free play of ideas.

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JOHN M. PETERS, M. D., *Secretary.*

JUNE 23, 1949.

COMMENTS ON S. 1106—THE MEDICAL AID OF 1949

This bill does not, like the others, pretend to establish a medical care program for the people. It merely proposes to aid them in meeting certain heavy costs for diagnosis and essential therapy that may arise in the course of disease. This is a rather narrowly conceived palliative measure. Although in individual instances the costs of these diagnostic and therapeutic measures may deprive persons of their benefits, they do not, in the majority of cases, constitute the major costs of illness and disability. These are the charges for professional services, hospitalization and the ordinary diagnostic and therapeutic procedures. If these cannot be met, expensive diagnostic and therapeutic measures will be of little avail. In fact those that need them may never become aware of this need.

We recognize the kindly intentions of this proposal and the desirability of such a measure as part of a general health program. By itself, however, it provides no adequate solution for the health needs of the Nation.

FEDERAL SECURITY AGENCY

SOCIAL SECURITY ADMINISTRATION—DIVISION OF RESEARCH AND STATISTICS

MEDICAL BENEFITS UNDER COMPULSORY HEALTH INSURANCE IN FOREIGN COUNTRIES (AS OF JANUARY 1, 1949)

Health insurance is the oldest form of social insurance. Compulsory insurance for a limited (occupational) coverage was established in the United States as long ago as 1798, when Congress enacted a hospital-care system for merchant seamen. The present marine hospitals of the Public Health Service are the outgrowth of that system. After long experience with voluntary insurance, the central European countries pioneered with broad compulsory coverage, beginning with the German law of 1883, followed by Austria in 1888 and Hungary in 1891. England adopted compulsory health insurance in 1911. In 1924, Chile adopted the first compulsory insurance law in the Western Hemisphere. In the Orient, the Japanese law of 1922 became operative in 1926–27.

Today, 39 countries have health insurance in operation and providing medical benefits to the extent noted in the table. All but two (Panama and Paraguay) pay cash sickness (disability) benefits also. In at least two other countries (India and Guatemala) laws already enacted are the subject of active preparation looking toward provision of medical benefits. Three countries (Argentina, Cuba, and Turkey) have maternity insurance only.

Coverage

Of the 39 systems, 7 explicitly or in effect cover all or nearly all inhabitants, and one (Sweden) is scheduled to do so in 1951. Subject to the limitations mentioned below, 20 of the other 31 systems cover practically all persons working for an employer, including agricultural and domestic workers. The remaining 11 cover workers in commerce and industry. In a few cases, higher-salaried white-collar workers are excluded from coverage. Public employees may fall within the scope of the general system, but in some countries have their own program, and in some are not insured.

A few countries which have national laws but which are only partly industrialized (mainly in Latin America) are bringing their programs into effect in the more industrialized sections of the Nation first.

Scope of benefits provided

Two countries, Ireland and Australia (which now have legislative power to do so) do not cover general practitioner services, but all provide specialist services, although one (New Zealand) makes no provision for higher payments for specialist care. The scope of specialist services varies. Prescribed medicines—in a few cases after payment of a nominal fee—are covered almost without exception. Some dental services are usually included.

Hospitalization is covered by virtually all program, but availability of hospital beds is often a limiting factor. Where existing facilities have proved inadequate to meet the demand, health insurance has usually made possible the construction and maintenance of enlarged facilities, with resulting provisions of more specialist services and their improvement.

Medical benefits for dependents

Services for the dependents of the insured worker have increasingly been included, and today 31 of the 39 systems make little or no distinction between the medical care provided the insured worker and that provided to his family. Three other countries assure maternity services to the worker's wife and have pediatric care for infants, though not covering dependents generally. Five do not cover dependents, but in at least two of these cases voluntary insurance is available for family members through the program.

Administration

In many cases, administration of compulsory health insurance is in the hands of health insurance societies (often termed "sickness funds"), which may be relatively small agencies serving a given area, factory, or trade-union. Where such a pattern exists, Government supervision is the rule, but the autonomy of the societies, through not absolute, is often jealously guarded by the insured persons. In a number of countries, particularly in the British Commonwealth, a Government agency administers the benefits directly. In six cases, medical care is provided by the Ministry of Health and not by the agencies administering cash benefits. The usual pattern in Latin America (also to be found in some other countries) is the autonomous institution, a corporation operating under national law and government supervision but making its own internal rules, contracting for services, and handling its own funds subject to the provisions of the legislation.

Compulsory health-insurance programs: Coverage and medical benefits [1]

Country	Year of first law	Coverage				Benefits			
		All, or nearly all, persons	Wage and salary employees		Dependents also entitled	General practitioner	Specialists	Prescribed medicines	Hospital care
			All, including agriculture	Mainly commerce and industry					
Albania	1947	-------	X	-------	X	X	X	X	X
Australia [1]	1945	X	-------	-------	X	-------	-------	X	X
Austria	1888	-------	X	-------	X	X	X	X	X
Belgium	1944	-------	X	-------	X	X	X	X	X
Brazil [1]	1923	-------	-------	X	X	X	X	-------	X
Bulgaria	1924	X	-------	-------	X	X	X	X	X
Chile [1]	1924	-------	X	-------	-------	X	X	X	X
Colombia [1]	1946	-------	-------	X	-------	X	X	X	X
Costa Rica [1]	1941	-------	-------	X	X	X	X	X	X
Czechoslovakia	1888	-------	X	-------	X	X	X	X	X
Denmark [1]	1892	X	-------	-------	X	X	X	X	X
Dominican Republic [1]	1947	-------	X	-------	-------	X	X	X	X
Ecuador	1935	-------	-------	X	-------	X	X	X	X
France	1928	-------	X	-------	X	X	X	X	X
Germany	1883	-------	X	-------	X	X	X	X	X
Great Britain [1]	1911	X	-------	-------	X	X	X	X	X
Greece	1934	-------	-------	X	X	X	X	X	X
Hungary	1891	-------	X	-------	X	X	X	X	X
Iceland	1936	X	-------	-------	X	X	X	X	X
Ireland [1]	1911	-------	X	-------	-------	-------	X	X	X
Italy	1928	-------	X	-------	X	X	X	X	X
Japan	1922	-------	X	-------	X	X	X	X	X
Luxemburg	1901	-------	X	-------	X	X	X	X	X
Mexico [1]	1942	-------	-------	X	X	X	X	X	X
Netherlands	1929	-------	X	-------	X	X	X	X	X
New Zealand [1]	1938	X	-------	-------	X	X	-------	X	X
Norway	1909	-------	X	-------	X	X	X	X	X
Panama [1]	1941	-------	-------	X	-------	X	X	X	X
Paraguay [1]	1943	-------	-------	X	X	X	X	X	X
Peru [1]	1936	-------	X	-------	-------	X	X	X	X
Poland	1920	-------	X	-------	X	X	X	X	X
Portugal	1933	-------	-------	X	X	X	X	X	X
Rumania	1912	-------	X	-------	X	X	X	X	X
Spain	1942	-------	X	-------	X	X	X	X	X
Sweden [1]	1947	X	-------	-------	X	X	X	X	X
Switzerland [1]	1911	-------	X	-------	X	X	X	X	X
U. S. S. R.[1]	1922	X	-------	-------	X	X	X	X	X
Venezuela [1]	1940	-------	-------	X	X	X	X	X	X
Yugoslavia	1922	-------	-------	X	X	X	X	X	X

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[1] For explanations and qualifications, see p. 4.

EXPLANATIONS AND QUALIFICATIONS OF CHART ENTRIES

Australia.—Comprehensive tuberculosis service is also available for all citizens. In addition, under the National Health Service Act (No. 81 of 1948, December 21), the Government proposes to meet 50 percent of the medical fees charged by means of direct payment to doctors. This law also provides for expansion of medical services.

Brazil.—Commercial and public-utility, bank, transport, and maritime workers receive medical services under social insurance programs. Workers in industry receive only cash benefits under social insurance, but in urban areas receive medical and other services from special employer contribution under employer-managed social service. Maternity care and medicines are not generally available. The date shown for Brazil's first law is that of the railway workers; most legislation dates from the 1930's.

Chile.—Maternity care for the wife of the insured worker, and pediatric services for infants under age 3, are available under the Chilean program; otherwise, an additional voluntary contribution is required to cover dependents. Provisions for salaried employees' medical care are much more restricted than under the wage earners' system, and consist primarily of preventive medical services and loans for other types of care.

Colombia.—Legislation is nation-wide in scope, but the program is being put into operation, beginning April 1949 (first benefits scheduled for September 1949), in the more industrialized areas first.

Costa Rica.—Legislation is nation-wide in scope, but the program is being put into operation first in the more industrialized areas and is not yet available throughout the country.

Denmark.—Under a quasi-compulsory system, in which membership in a sickness fund is linked with eligibility for old-age pensions, approximately 85 percent of the population is insured against sickness. Persons having income in excess of the approximate annual earnings of a skilled worker are not eligible for active membership in a sickness fund.

Dominican Republic—Maternity care for the wife of the insured worker and pediatric services for infants up to 8 months of age are the only services provided to dependents.

Great Britain.—The comprehensive National Health Service program, with services provided irrespective of insurance status to all residents, was enacted in 1946, effective 1948.

Greece.—Same as Costa Rica.

Ireland.—Medical benefits—which do not include general practitioner or obstetrical services—are provided after a qualifying period of 3 years and payment of 104 weekly contributions. The Irish system is primarily concerned with cash benefits for sickness (disability) wage-loss.

Mexico.—Same as Costa Rica.

New Zealand—The regular payment of 7 shillings, 6 pence for a visit to a general practitioner is also available for specialist services, but no additional payment is made.

Panama.—Same as Costa Rica.

Paraguay.—Same as Costa Rica.

Peru.—Same of Costa Rica.

Sweden.—The Swedish act of 1947, introducing compulsory insurance, is scheduled to take effect July 1, 1951. Maternity care is to be provided outside of insurance. The present voluntary program has wide coverage and provides similar services.

Switzerland.—A Federal enabling act exists, but coverage varies by canton, and insurance is not compulsory in all cantons. Recognized sickness societies are subsidized everywhere in the country (56 percent of population insured, 1945).

U. S. S. R.—The U. S. S. R. has public medical service, apart from insurance, for all persons. A fee is charged for medicines. Pre-Soviet Russia had a health insurance law, adopted in 1912.

Venezuela.—Same as Costa Rica.

(Senator Pepper submitted the following material for inclusion in the record:)

[Reprinted from the New York Times Magazine, May 8, 1949]

(Submitted by the Committee for the Nation's Health, Inc., Washington, D. C.)

THE CASE FOR NATIONAL HEALTH INSURANCE

SENATOR HUMPHREY HOLDS PRIVATE MEDICAL CARE AND VOLUNTARY PLANS TOO COSTLY FOR MOST PEOPLE

(By Hubert H. Humphrey [1])

As a member of the new Senate Subcommittee on Health, I have just finished my home work—boning up on 10 volumes of testimony gathered by two earlier subcommittees on this question: How can we best bring adequate medical care within the reach of all our people?

To date, 5,890 pages of answers have been accumulated. For Congress, the very soul of caution, has been gingerly weighing the merits of voluntary versus compulsory health insurance ever since 1939.

Admittedly, the task before Congress is difficult. Good health cannot be legislated into existence. Nor can any simple prescription, hastily conceived or carelessly compounded, improve the Nation's health. But after more than a decade of examination and debate, and in the light of experience with voluntary prepaid programs, I believe we can at least agree on a frank diagnosis of what is hurting us.

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[1] Hubert H. Humphrey is a Democratic Senator from Minnesota and former mayor of Minneapolis. He has been actively interested in medical matters for the past 15 years.

The cause of our malady is essentially economic. We suffer from the high cost of medical care. American medicine, undoubtedly the world's finest, is priced beyond general purchasing ability. This fact was brought out in 1939 by the American Medical Association's own bureau of economics. Its study disclosed that families with incomes below $3,000 could not meet serious illness costs without outside aid.

Bring those figures up to date by compensating for a 10-year spiral in living costs and the $3,000 mark soars to $5,000. Today, four out of five families fall below this standard of medical self-sufficiency. Consequently, the threat of doctor and hospital bills hangs over 80 percent of our people. For most of us serious illness means all too frequently wiped-out savings, unpaid bills, and mortgaged futures.

Medical care is not only expensive; it is poorly distributed as well. Doctors, hospitals, nurses, dentists, and other professionals are often in scarcest supply where the need is greatest. Gleaming doctors' plates crowd each other for space on city apartment houses. (Cities average 1 doctor per 500 people.) But weathered wooden shingles are fast disappearing along with their practitioners from our countryside. Some rural States now average only 1 doctor per 1,700 people.

Where hard cash is short and medical attention scant, high sickness rates prevail. A few heart-breaking statistics drive home the thesis that low income equals poor health. Only one out of two southern mothers can afford or receive needed childbirth care. Result: 9 out of 10 States with the highest maternal death rate in 1946 were Southern States. In the low-income States of Alabama, Georgia, Mississippi, and South Carolina, the death rate among women in childbirth, for example, is three times as high as in Connecticut, Minnesota, or Rhode Island.

Infant death rates repeat the same tragedy. In four low-income States, 50 to 100 babies died in their first year, compared with 28 to 30 babies per 1,000 live births in four high-income States.

Shocking figures? Yes; and all the more so because they stem from the dismal economic cause we have thus far failed to remedy: The price of medicine in the market place is too high.

Let us keep this broad picture of our health needs in mind as we examine the two principal solutions that have been proposed: voluntary versus national health insurance.

The achievements of voluntary plans in most areas of American life are impressive. In fact I should state that a Nation-wide system of voluntary organizations for medical care with adequate coverage is more consistent with my personal and political philosophy than a Government-established program. I would, indeed, warmly welcome a national network of such voluntary cooperative health plans as the Group Health Mutual in my own State of Minnesota and the Group Health Association in Washington, D. C.

These truly voluntary plans are not, however, what is intended by those who would oppose a national health insurance program on the ground that "voluntary plans can fill the need." Rather, many of those, led by the lobbyists of organized medical societies which now champion their own brand of voluntarism, are the very ones who have persistently impeded the growth of cooperative medicine—the very essence of voluntarism. The law reports and legislative hearings provide ample evidence of that. For example, the Group Health Cooperative in Minnesota, because of opposition of certain spokesmen of the organized medicine societies, has been unable to obtain enabling legislation despite the support of the Governor. Similar opposition is being met by cooperatives in Wisconsin.

In reality therefore the voluntary plans being championed by opponents of the national health insurance program are outlined, prepared and directed by the doctors and hospital personnel and not by the public, which is most directly affected by the lack of adequate health facilities. Curiously enough the representatives of the medical societies now urging their form of voluntarism are the same ones who not so long ago opposed the plans they now endorse.

Where and how do these voluntary plans fall short? Let us judge them by four important criteria, which should be applied to any program purporting to improve our Nation's health:

(1) Coverage: Is it Nation-wide in scope so that all our people are covered?

(2) Comprehensiveness: Does it pay for almost all medical services of an average family?

(3) Sound administration: Is the plan administered in the public interest?

(4) High-quality care: Does it firmly guarantee professional freedom so essential to doctors, nurses, and hospitals? Does it promote better standards of medical care?

Two factual surveys of voluntary health insurance plans were released recently by the Committee on Research in Medical Economics, a nonprofit group which has pioneered in this complex subject. The first report analyzed the relative scope of voluntary plans, the protection offered, the number and geographical distribution of people served.

The findings may be summarized as follows:

COVERAGE

The general shortcomings in this field may be glimpsed in a few statistics on how many people have what kind of protection.

Hospitalization insurance only: 27,000,000 people.

Hospitalization insurance plus physician's services in hospital: 27,000,000 people.

Comprehensive plans, including preventive care: Only 3½ million people. In other words, about 1 out of every 40 persons enjoys reasonably complete protection through voluntary programs.

In rural areas less than 3 percent of the population presently subscribe to the Blue Cross hospital plan.

Eighty-five million Americans have no protection against crippling sickness costs. The reason? Voluntary plans are priced beyond the reach of that great middle-income group which needs such protection most. Since these plans have no sliding scale of payments to match income, their rates are too steep for many pocketbooks. The same conclusion is reached by the Journal of the American Public Health Association:

"Both logic and experience indicate that such a program does not—and cannot—reach the large middle group of the population.

"Nor can the issue be solved by asking families to join in support of voluntary insurance and pay out money which they do not possess."

COMPREHENSIVENESS

Voluntary health insurance, although an excellent aid, does not cover even the major part of the subscriber's annual sickness bills. Hospitalization insurance, such as Blue Cross, covers only 21 percent of an average family's annual medical bill. Add physician's services in a hospital—Blue Shield—and it still remains relatively low, only 35 percent.

These combined plans, the largest in existence, do not meet such important day-to-day medical costs as protection against common illness, periodic check-ups, immunizations or inoculations, or prenatal and postnatal care. The services of a family doctor or a specialist in his office or at the patient's home are not provided. Preventive medicine is not possible.

SOUND ADMINISTRATION

Sound administration requires a division of responsibility between the professionals who provide the health services and the consumers who pay for them. Certainly all medical matters should be left strictly in the hands of doctors. But by the same token those who foot the bills should have more control over such lay matters as administrative details, scope of benefits, eligibility of membership, subscribers' fees, etc.

To deny the public its proper voice in the administration of voluntary programs is to invest medical societies with all the powers of a monopoly and none of the checks against the abuse of that power. Unfortunately, there is abundant evidence showing how organized medicine is presently exploiting its quasi-monopoly position.

A study by the Committee on Research in Medical Economics, recently completed, reports that State and local medical societies use restrictive State legislation, boycotts and other professional pressures to block the growth of health-insurance plans providing comprehensive services. These plans, competing with the Blue Cross and Blue Shield, are sponsored by industries, unions, cooperatives, farmers and other consumer groups. Special laws passed with the approval, if not at the request of medical societies have been enacted in 22 States. These laws prevent the establishment of voluntary health-insurance plans unless they are controlled by organized medicine.

The report of the Committee on Research further declares:

"The medical societies not only refuse to sponsor the type of health-insurance plan which professional opinion has recommended as able to offer the most adequate medical service at reasonable cost, but also have endeavored to prevent their individual physician members from participating in such plans.

"They have choked the development of * * * comprehensive health services, in favor of plans offering only very limited services.

"They have restrained doctors from free experimentation in improved forms of medical service and have prevented the people from experimenting with improved methods of payment for service."

HIGH-QUALITY CARE

The study further declares that the AMA defends its opposition to consumer medical plans on the ground that it is guarding the "standards and quality of medical service." But, states the report, "the medical societies cannot claim that the health-insurance plans which they control guarantee the quality of professional care." On the other hand, the study points out, many of the consumer-operated plans do provide high quality medical care through group practice and preventive medicine which have been repeatedly recommended by professional authorities.

The distinguished chairman of the Committee on Research in Medical Economics, Dr. Michael M. Davis, once summed up the case against voluntary health insurance in these words: "Voluntary plans do not offer broad enough coverage at low enough rates to a large enough portion of our people to justify serious consideration as a national solution of our national problem."

All of this evidence compels recognition that the four basic criteria of coverage, comprehensiveness, sound administration, and high-quality medical care are not met by vluntary plans. They are at best stopgap defenses in the battle against medical cost.

But some people ask: "Why not overcome the cost factor by subsidies to voluntary plans for those people unable to meet premiums?"

The proposal is attractive on the surface but further reflection uncovers its many defects. First: It would inevitably require a "means test" to decide who can or cannot afford the premium. We would thus be turning the clock back to the odious "charity principle" of the nineteenth century. Second: To protect tax funds from misuse, it would require an army of bureaucrats constantly prying into each family's income and job status to check on eligibility. Third: It would involve Federal subsidies to private plans which are essentially run by organized medicine, not by the public.

Now we come to the heart of the controversy—the national health program the President has requested. Following his special message on April 22, an improved comprehensive health bill was submitted by eight Senators and two Congressmen.

The bill specifically guarantees that payments for benefits shall be in proportion to incomes, and persons "shall, therefore, obtain services as a right and not as a charity; that they shall be insured the free choice of their doctors; that physicians and other professions furnishing services to them shall be assured freedom in the practice of their profession and assistance in maintaining high standards, and that the administration of this act shall be based upon the American principle of decentralization."

Administrative responsibility is accordingly placed "in the hands of local bodies representing both those who pay for and those who render services, and operating within the framework of plans made by the several States. * * *" This provision, incidentally, though recognizing the role of volunteer plans and providing for their operation, does not give adequate protection to all volunteer nonprofit plans, such as cooperatives, whose operation may be opposed by State medical societies. I am, therefore, introducing an amendment to correct this weakness.

The bill bans "discriminations because of race, color, or creed," and would allot substantial funds annually for scholarships, grants to professional schools for research, and concrete aid to underdoctored areas, such as ambulance services and subsidies to young doctors.

As drawn, the bill would cover approximately 85 percent of the population. It includes employees, self-employed persons, and their dependents.

As a former practicing druggist of many years' experience and an admirer of the tremendous achievements of the American medical profession, I was particularly critical in examining guarantees of professional freedom. A careful scrutiny of the bill and of the testimony presented on previous measure before subcommittees, assures me that there is no danger to the professional freedom so essential to doctors, nurses, and hospitals. None of these is placed under Government control, and the patient has the unqualified right to go to the doctor of his choosing or to change doctors. Furthermore, millions of persons who today do not have free choice of physician because of economic barriers will have that privilege for the first time. The bill also scrupulously protects the private relationship that should exist between a doctor and his patient.

Thus the national health insurance bill measures up to the four standards by which we have judged voluntary health insurance:

It would cover almost all our people.

They would receive virtually complete protection against all medical hospital bills.

Local control and the principle of decentralization are stressed repeatedly.

High-quality medical care would be stimulated.

What then of the serious objection raised in some quarters that the national health insurance plan is primarily a blueprint, not a working plan?

Some physicians reject the AMA's tactics and recognize that the present fee-for-service system is unsuited to our needs and that "voluntary" insurance has insuperable, deficiencies. But, at the same time, they argue: "National health insurance promises more than can be delivered. It would impose crippling demands on our present overtaxed facilities. * * * We need time, more time to prepare."

These critics have been calling for time for the last ten years. Yet the desired expansion has not come. Nor can it come so long as medical care is circumvented by restricted purchasing power. We may build more hospitals, train more doctors, and discover new cures. But they must be supplemented by pooled purchasing power to pay for hospital care in each community to be effective.

To wait for promised expansion before we seek to provide pay for health care is to blind ourselves to the hard facts of medical economics. A sound plan strives to create a financial base first and accepts the necessity of a brief "tooling up period" to train personnel and build facilities.

Foreign experience serves as no necessary criterion, but for those who like to look before they leap, Great Britain's progress under its now National Health Service Act is enlightening. While differing from our proposed program in some respects, the British plan spreads and spaces the costs of medical care. Both work on the tested insurance principle of pooling resources to face a common risk. In the 10 months since the British act went into effect (July 5) professional medical opinion (once opposed), the Conservative Party and the British people have provided evidence of the act's tremendous acceptance.

Said the Lancet, long established independent British medical publication:

"Both doctor and patients are pleased with their new and easier relationship. * * * Patients are also grateful to observe that the new service is truly comprehensive. * * * Complaints are few."

The Conservative Party virtually lost the important by-election at Hommersmith before they could reverse their policy and endorse the British Health Service Act. Official Conservative Party policy is now to promise the act's retention and to point to the important role played by Winston Churchill in sponsoring the program in 1944.

The last and most compelling endorsement of the act comes from the people themselves. The British Institute of Public Opinion reported that British voters named it the Attlee Government's best act: "It far outranked any other measure in popularity."

For 10 years we have been diagnosing our problem, studying the operation of voluntary programs here and national programs abroad. Now the urgency of the situation compels us to act.

FEDERAL SECURITY AGENCY,
SOCIAL SECURITY ADMINISTRATION,
DIVISION OF RESEARCH AND STATISTICS,
June 3, 1949.

COVERAGE AND CONTRIBUTIONS UNDER HEALTH INSURANCE (S. 1679; H. R. 4312; H. R. 4313)

The health-insurance plan of S. 1679 and H. R. 4312 and H. R. 4313 provides first that all normally self-supporting persons shall help prepay, while they are working and earning, the costs of medical care for themselves and their dependents. It further provides that other persons can be brought into the same system of arrangements for medical care by special provisions for payment of premiums on their behalf.

Compulsory coverage

Employed persons (including the self-employed).—The bills cover compulsorily all employed persons (both those employed by others and those who are self-employed) except railroad workers, employees of State and local governments, persons in military service and various small marginal groups (sec. 704 and sec. 781 (a) (b) (c)). Those covered include:

Employees in industry and commerce.
Agricultural workers.
Farmers.
Other persons in business for themselves, such as owners of small businesses, shopkeepers, professional people.
Employees of nonprofit agencies (except ministers, etc.).
Domestic employees.
Federal Government employees.

Dependents.—The families of employed persons are covered automatically if the worker himself is eligible (sec. 704 (a) (3), (b) (3)). Qualified dependents include the wife, unmarried children under 18 or disabled children of any age, a disabled husband and parents living with or receiving regular and substantial support from the worker (sec. 781 (k)).

Social-insurance beneficiaries.—The bills also cover automatically certain persons who have been in gainful employment during their working lives but are now retired, and their dependents, or persons who are the dependents of deceased gainful workers. Specifically, they cover persons receiving monthly retirement, survivor or disability benefits under old-age and survivors insurance and the civil-service retirement system for Federal employees, and their dependents (sec. 704 (a) (2) (3)).

Number of persons covered compulsorily.—About 80 percent of the population would be covered under S. 1679 and H. R. 4312 and H. R. 4313 through the provisions that apply to earners and their dependents. The provision relating to social-insurance beneficiaries and their dependents would today automatically bring under coverage another 1.5 percent of the population. In time, particularly if the average of old-age and survivors insurance is broadened and disability protection added, this provision would assure prepaid medical-care benefits to almost all persons aged 65 and over, to almost all orphans under 18 and to widowed mothers with young children in their care, and to most permanently disabled workers and their families.

Coverage through arrangements by public agencies

In addition to those covered compulsorily, the bills make possible the coverage of any other persons in the population if equitable premiums are paid on their behalf by some public agency (sec. 705). Groups who might be covered under this provision include:

1. *State and local government employees.*—State and local employees are not covered compulsory because there is a question whether, under our Constitution, State and local governments can be required to pay social-insurance contributions, which have the legal status of taxes. Under the bills, State and local employees, beneficiaries of State and local retirement systems, and their dependents could be brought under coverage through voluntary agreements between the States and the insurance system. These groups represent about 4 percent of the population.

2. *Public-assistance recipients and others.*—The other groups most likely to be brought under coverage through arrangements by public agencies are the re-

cipients of public assistance. The bills amend the Social Security Act so that Federal public-assistance grants to the States may include money to pay the health-insurance premiums for such persons. At the present time, those public-assistance recipients who would not be insured on the basis of previous employment or as dependents represent about 2 percent of the population. Others who might be brought in through payment of premiums on their behalf by public agencies are dependents of persons in military service, or persons receiving certain types of veterans' benefits would not qualify on the basis of their own employment.

Persons not covered initially

The persons who might remain outside of coverage initially, in addition to railroad workers and their dependents, would be persons who did not qualify as earners, or as dependents or survivors of earners from among such groups as the following:

- Students over 18.
- Young girls over 18 and other nonmarried women living at home or with relatives.
- Persons disabled before they could qualify for benefits.
- Persons retired on their own income or before the age at which old-age and survivors insurance benefits are payable.
- Persons in institutions.

Number and proportion of population covered

In summary, the health-insurance plan of S. 1679 and H. R. 4312 and H. R. 4313 would at the outset automatically cover some 80 to 85 percent of the population as earners and their dependents, or as old-age and survivors insurance or civil-service beneficiaries and their dependents. It provides further for the coverage, through agreements, of State and local employees and their dependents, constituting another 4 percent, and of public-assistance recipients who would not otherwise be covered, representing another 2 percent of the population, and would make possible the eventual coverage of the entire population or nearly all of it if the appropriate arrangements were made by public agencies.

Coverage under S. 1679 and H. R. 4312 and 4318 in 1950

	Number (total population of 150,000,000)	Percent of population
	Millions	
Total compulsory coverage	119–127	80–85
Total compulsory coverage plus coverage that might be achieved directly or soon thereafter through arrangements with public agencies	128–135	85–90
Compulsory coverage:		
Earners and their qualified dependents (employees in industry and commerce; agricultural workers; farmers; other self-employed persons; employees of nonprofit agencies; domestic employees; Federal Government employees)	117–125	78–83
Social-insurance beneficiaries and their dependents not otherwise qualified	2.2	1.5
Coverage authorized through arrangements with public agencies:		
State and local government employees and their qualified dependents	5.5	3.7
Beneficiaries of State and local government retirement systems	.3	.2
Public-assistance recipients not otherwise qualified	2.5	1.7

Eligibility requirements

The eligibility requirements of S. 1679 and H. R. 4312 and 4313 would result in qualifying all persons who are normally employed (in the covered occupations) and their dependents. The right to the medical benefits would normally be determined for everybody once a year and would apply throughout a benefit year beginning on July 1 and running through the following June 30 (sec. 781 (d)). Thus persons needing care and doctors, hospitals and other providers of services would know who is entitled to have his medical care paid for by the health-insurance system.

A worker can qualify if he meets either of two tests:

The first is a test of recent employment. It requires earnings (including income from self-employment) of at least $150 in the calendar year immediately preceding the July 1–June 30 benefit year (an average of less than $3 a week) (sec. 704 (a) (1) (A)).

The second test rests on longer but possibly interrupted employment. It requires earnings (including income from self-employment) of at least $50 (an average of less than $4 a week) in each of six calendar quarters (a total of 1½ years) out of the three calendar years (12 quarters) immediately preceding the benefit year (sec. 704 (a) (1) (B)).

(The interval of time between the end of the calendar year and the beginning of the benefit year is reserved for the reporting of income and earnings, the setting up of wage records, and the determination of benefit rights.) Under the second of these two alternative tests, a worker who had been unemployed or sick for as long as 2 years immediately prior to a benefit year could still retain his rights to medical benefits for himself and his family during another benefit year. Furthermore, there is a special provision which continues indefinitely the rights of persons who suffer a total disability after having earned at least $50 in each of six calendar quarters within a 3-year period (sec. 704 (a) (1) (B)).

If eligibility determinations were made only once a year, new workers or persons newly reentering the labor force—older women, for instance—might have to wait for some time before they could qualify for medical benefits. S. 1679 and H. R. 4312 and 4313 provide that persons who fail to qualify at the beginning of a benefit year may reapply at the beginning of any succeeding calendar quarter. If they then meet the earnings requirements, they will become eligible for benefits for the remainder of the benefit year (sec. 704 (b)).

Except in periods of very serious and long-continued depression, and in such periods special arrangements might be made, any persons who ordinarily have any appreciable amount of gainful employment, and their dependents, would qualify for the health-insurance benefits.

Eligibility for persons covered through arrangements by public agencies.—Persons covered through payment of premiums on their behalf by public agencies would have the same rights to medical care as persons covered compulsorily. Ordinarily they would be covered throughout the July 1–June 30 benefit-year; but arrangements could also be made for those who had not been brought in at the beginning of the year to become eligible later in the year. While the bills do not specify the detailed administrative arrangements, it is probable that all eligible persons or families would receive some kind of insurance card which they could use throughout a benefit-year to show that they were entitled to the health insurance benefits, with persons covered through payment of premiums on their behalf receiving the same kind of cards as those covered compulsorily.

Contributions and costs

Under S. 1679 and H. R. 4312 and 4313 amounts equal to 3 percent of the earnings (including income from self-employment), up to $4,800 a year for each individual covered compulsorily, would be paid into a personal health services account in the United States Treasury (sec. 771). The bills do not specify, but the sponsors have indicated, that workers might pay half and their employers half of these contributions (1½ percent of taxable earnings, each), with self-employed persons paying the full amount or something less.[1] The bills provide for an appropriation to the account in the fiscal year 1951 of an amount equal to 1 percent of taxable wages in that year, in order to provide a small reserve by the time benefits become payable. The bills do not specify whether this amount would come from general revenues or from employee and employer contributions.[1]

In addition to the amounts equal to 3 percent of taxable earnings (and presumably to be covered by employee and employer contributions), the bills provide for additional appropriations (presumably from general revenues) as necessary, but these additional amounts are not to be more than one-half of 1 percent of taxable earnings for each of the first 3 years after benefits are payable, and not more than 1 percent for each of the next 3 years. Thereafter Congress would decide what amounts were needed (sec. 771).

In addition, equitable premiums would be paid to the personal health services account on behalf of groups covered through special arrangements. In general, it may be assumed that the amounts paid into the account on behalf of such groups would balance the amounts paid out for their medical services.

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[1] The sponsors have said that these aspects of financing would be settled in a separate "tax" bill which would be necessary to implement the substantive program agreed upon.

The estimated amount of earnings on which contributions would be payable (counting only the first $4,800 of an individual's earnings in a year) in 1950—if the contributions applied to that year—are as follows (assuming general economic conditions similar to those prevailing in late 1948):

Estimated taxable earnings, 1950

	In billions
Compulsory coverage	$133.7
Wage earners:	
Industry and commerce	100.0
Agriculture	3.0
Domestic employment	2.2
Nonprofit institutions	2.1
Federal civilian employment	6.4
Self-employed persons	20.0

Thus, with taxable earnings of about the amount estimated for 1950, the maximum funds available to pay for medical care for those compulsorily covered under S. 1679 and under H. R. 4312 and 4313 would be 3½ percent of taxable earnings or 4.7 billion dollars in each of the first three benefit-years, and 4 percent of taxable earnings or 5.3 billion dollars in each of the next three benefit-years.

DIVISION OF RESEARCH AND STATISTICS,
SOCIAL SECURITY ADMINISTRATION,
FEDERAL SECURITY AGENCY,
May 1949.

ESTIMATE OF EXPENDITURES FOR A NATIONAL HEALTH INSURANCE PROGRAM (AT LATE 1949 PRICE AND INCOME LEVELS)

I. INTRODUCTION

The Division of Research and Statistics receives many requests for data on the amount that presumably would be expended for personal health services under a national system of health insurance. This memorandum was prepared to answer such inquiries.

Estimates of health insurance expenditures necessarily depend on the specifications assumed for the insurance system. For present purposes, the estimates have been developed by revision of data originally contained in a 1946 report which used a particular set of assumptions and premises as to coverage, benefits, and other specifications. Obviously, the cost estimates have no particular meaning apart from those assumptions and premises, and the figures do not necessarily apply to any particular legislative proposal. They do not include public expenditures, financed out of general revenue, for public health, for mental and tuberculosis institutions, or for services furnished to the armed forces and to veterans.[1]

A national health insurance system may not cover the whole population initially, but it may eventually. Nevertheless, some of the estimates are shown as though they applied to the total civilian population, so that they may be comparable in this respect with national data on actual expenditures made by all consumers. In order to adapt the figures to less than complete coverage, the estimated per capita expenditures are multiplied by the population estimated for a limited coverage. (Such a calculation assumes that the population of the limited coverage is like the total population with respect to expected per capita costs.) The revised estimates therefore deal first with the per capita costs, and then with estimates for national coverage and for a coverage which extends to the labor force and its dependents (about 85 percent of the population).

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[1] Under health insurance there could be some shift of veterans' hospitalization and medical care practices, especially for non-service-connected cases, so that relatively more such service would come within the scope of health insurance costs and relatively less would remain outside the insurance system. To the extent that this happened, the costs of the insurance system would be increased, but the increase would be offset by reduction in Federal general-revenue expenditures for hospitalization and medical care of the veterans.

II. THE REVISED ESTIMATES (LATE 1948) AND COMPARISON WITH THE EARLIER ESTIMATES (1945–46)

The revised cost estimates, at late 1948 price and income levels, are shown in three tables. The earlier estimates, at 1945–46 price and income levels, are shown in parallel columns for comparison. In each table, the figures are given for an initial or early year of health-insurance operation and for the later year "195X." The latter figures (195X) were intended to show the probable increase in costs when services had become more comprehensive, some 5, 10, or 15 years after the program had begun.

Table A shows the per capita cost estimates. Table B shows the cost estimates that result when the per capita figures are applied to total civilian population (using 140,000,000 for 1945–46, and 146,000,000 for late 1948). Table C shows the corresponding cost estimates when the per capita figures are applied to an estimated labor-force coverage which includes gainfully occupied persons and their dependents who would qualify for insurance benefits (120,000,000 for 1945–46, and 125,000,000 for late 1948). Thus, the increases in costs shown in the revised estimates for late 1948 in tables B and C reflect increases in per capita costs resulting from higher price and income levels and increases in population (total or labor force). As before, a constant population is used for the comparisons between initial or early years and later years (195X) of operation.

As in the case of the 1945–46 estimates, the revised figures include in the estimate for each item an allowance (5 to 7½ percent) for administrative costs.

III. COST ESTIMATES IN RELATION TO EARNINGS

While the cost estimates for national health insurance have increased, so have wages and earnings. Consequently, the cost estimates have not changed greatly in relation to the incomes from which they would be financed.

Consider first the national health insurance cost estimates which assumed coverage of the total civilian population (table B). In 1945–46, national income was 180.5 billion dollars; in late 1948 it was at the rate of 224.5 billion dollars. When related to these figures, the cost estimates give the following results:

Price and income level	Estimated insurance cost		Percent of national income	
	Initial or early year	195X	Initial or early year	195X
	Billions	*Billions*		
1945–46	$4.03	$5.45	2.23	3.02
Late 1948	5.37	7.27	2.39	3.24

Thus, even though the initial or early year cost estimates for the health insurance program have increased 1.34 billion dollars (about 33 percent) at the higher price, income and population levels of late 1948, the difference between 1945–46 and late 1948 costs represents an increase of only 0.16 percent of the national income. Similarly, the cost estimates for the program at a future date, when no further increase in either the national income or the population is assumed, have risen only 0.22 percent of the national income.

Consider now the cost estimates for the labor-force coverage (table C). Adjustments for changes in price and income levels and population increased the figures for an initial or early year of insurance operation from 3.45 billion dollars at 1945–46 price and income levels to 4.59 billion dollars at late 1948 levels; and for a later year of operation (195X), from 4.66 to 6.22 billion dollars. These figures may be measured against earnings from gainful employment that might be subject to an insurance contribution rate. For 1945–46, the earnings base was 109 billion dollars, assuming total civilian labor force coverage and a $3,600 maximum on the individual's contribution base. The figure for late 1948 is $139,000,000,000 with a $3,600 maximum, and $148,000,000,000 with a $4,800 maximum. Thus we have the following relationships:

Price and income level	Estimated insurance cost		Percent of covered earnings			
			Intial or early year		195X	
	Initial or early year	195X	$3,600 maximum	$4,800 maximum	$3,600 maximum	$4,800 maximum
	Billions	*Billions*				
1945–46	$3.45	$4.66	3.17	(3.03)	4.28	(4.09)
Late 1948	4.59	6.22	(3.30)	3.10	(4.47)	4.20

With this coverage, the 1945–46 cost estimates for an initial or early year amounted to about 3.17 percent of wages, salaries, and self-employment income up to $3,600 a year. At late 1948 price and income levels, the corresponding estimates amount to about 3.3 percent of such earnings up to $3,600 and to about 3.1 percent of such earnings up to $4,800 a year. Similarly, the cost estimates for 195X have moved up slightly from about 4.28 percent to about 4.47 percent with such earnings counted only up to $3,600 a year, and have moved down slightly to about 4.2 percent if the contribution base is adjusted to the higher level to take account of increases in earnings.

IV. SUMMARY OF METHODS USED IN REVISING EARLIER COST ESTIMATES

Estimates for an initial or early year.—Cost estimates for medical-care insurance were originally prepared in early 1946,[2] on the basis of late 1945 to early 1946 price and income levels, and related to the size of the estimated 1946 civilian population.[3] It has been necessary to revise these estimates for current discussions of the medical-care insurance program, because the population has increased about 6,000,000, or 4.3 percent, the national income has risen about 26 percent, the Bureau of Labor Statistics Consumers Price Index has increased about 33 percent (though the increase has not been uniform for all items of personal expenditure), the resources for providing services have changed somewhat and their costs have increased considerably.

The newer estimates have been prepared by revising the 1945–46 estimates to show the corresponding costs at late 1948 price and income levels, and with adjustment for the population increase.

The earlier estimates were developed and presented in terms of per capita costs. From these per capita amounts, the aggregate costs for the estimated 1946 population were obtained. The 1946 report included estimates for an initial or early year of program operations and also for a future year (designated as 195X) when the benefits were expected to have increased in scope and volume by reason of enlarged resources for service (personnel and facilities) and increased public demand for service. 195X was conceived as a year 5, 10, or 15 years after benefits first become available under the insurance system.

The cost data presented in chapter XV of the 1946 report (table 13, p. 147) have been used as the base from which upward adjustments to late 1948 price, income, and population levels were calculated.

Three methods—explained in detail in the appendix—were tested for the tentative revision of the initial or early year costs. Selections were then made among them for each of the six classes of benefits which, taken together, make up the aggregate cost.

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[2] Medical Care Insurance, a Social Insurance Program for Personal Health Services. Report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, July 8, 1946, 79th Cong., 2d sess., Senate Committee Print No. 5, 185 pp.

[3] The population used in the 1946 report (140 million) was the total population, including the armed forces, at the end of 1945, and was of necessity an estimate of what national coverage would probably be, since 6.6 million men were at that time in the armed forces at home and overseas, and the future size of this group was unknown. The figure of 146 million population for late 1948, used in this memorandum, excludes, however, 1.4 million persons in the armed forces. The 4.3-percent increase in population used in the preparation of the estimates in this report represents the difference between the estimated total population at the end of 1945 and the estimated civilian population for October 1948.

Method I assumed that the cost of each of the expenditure items had increased in the same proportions that prices for identical or related items had risen in the Consumers Price Index of the Bureau of Labor Statistics. These increases may accurately reflect changes in price per unit of service but they may understate the increases which have occurred in practitioners' incomes, especially if there has been an increase in total amount of service rendered, and they probably give disproportionately large increases for hospital services. (See appendix table 1 for details.) This method was not closely enough tied to recognized changes in most of the cost items to be generally applicable; but of the three methods, it was the most directly related to the item dealing with "laboratories, drugs and sundries, ophthalmic and orthopedic supplies," and was therefore used for deriving late 1948 figures for this class.

Method II used the Department of Commerce estimates of increases in personal consumption expenditures for items similar or related to those included as health insurance benefits. 1948 data were not available for the individual items. It was therefore necessary to project to 1948 the actual expenditures for 1947 on the basis of the known aggregate increase in the national income between 1947 and the third quarter of 1948. Though subject to some uncertainty, this nevertheless seemed to be the most meaningful method of determining increases for hospital expenditures in the period between 1946 and late 1948. The details are shown in appendix table 2.

Three of the remaining four items (physicians' services, dental care, and home nursing) are largely expenditures for personal services. Such expenditures determine the gross incomes of practitioners and, in turn, their net personal incomes. Method III therefore depended on increase in the national income and how it reflected personal incomes. It appeared to be the most valid method for deriving the adjustments for expenditures for physicians, dentists, and home nursing, because the original calculations had been based largely on the incomes such personnel had been receiving for their professional activities. It was therefore used in the revision of these three cost items. The last item of cost, "Research and education," was increased by the same rate as the increase in national income. The detailed methods used for these four items are shown in appendix table 3.

Explanation of the estimate for 195X.—The 1946 report also gave projections of the cost estimates to a future date, called for convenience 195X. No changes have been made, in this memorandum, in the anticipated percentage increases in costs between the initial or early year and the 195X estimates. The percentage by which the 1946 report estimated that each item should be increased to provide for expanded benefits is shown in the last column of table A. The 195X figures, therefore, bear the same relationships to the initial year figures in both the earlier and the present estimates. The premises for these projections to a future date are discussed in detail in the original report. They assume higher levels of adequacy in 195X than are practical in the initial or early years. It is recognized that uniformly high levels cannot be achieved simultaneously for all benefits.

TABLE A.—*Summary of illustrative per-capita health insurance costs* [1]

[At the price and income levels of 1945–46 and late 1948]

Benefit	Initial or early year costs		195X costs		Percentage increase between initial year and 195X
	1945–46	Late 1948	1945–46	Late 1948	
Total	$28.76	$36.81	$38.93	$49.83	35.0
1. Physicians' services	14.58	18.34	16.18	20.36	11.0
2. Hospital services	7.19	10.08	9.35	13.10	30.0
3. Dental care	3.00	3.78	7.13	9.00	138.0
4. Home nursing	.51	.64	1.24	1.55	143.0
5. Laboratory, medicines, and appliances	3.38	3.84	4.29	4.84	26.0
6. Research and education	.10	.13	.74	.98	(2)

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[1] Under health insurance there could be some shift of veterans' hospitalization and medical-care practices, especially for non-service-connected cases, so that relatively more such service would come within the scope of health-insurance costs and relatively less would remain outside the insurance system. To the extent that this happened, the costs of the insurance system would be increased, but the increase would be offset by reduction in Federal general-revenue expenditures for hospitalization and medical care of the veterans

[2] Fixed at 2 percent of the total cost of the program for 195X.

NOTE.—For the assumptions and premises underlying these illustrative costs, see the text and appendix of this memorandum and the 1946 report (footnote 2).

TABLE B.—*Summary of illustrative health insurance costs for coverage of total civilian population* [1]

[At the price and income levels of 1945–46 and late 1948]

Benefit	Initial or early year		195X	
	1945–46 (140,000,000 persons)	Late 1948 (146,000,000 persons)	1945–46 (140,000,000 persons)	Late 1948 (146,000,000 persons)
	In billions of dollars [2]			
Total	4.03	5.37	5.45	7.27
1. Physicians' services	2.04	2.68	2.27	2.98
2. Hospital services	1.01	1.47	1.31	1.91
3. Dental care	.42	.55	1.00	1.31
4. Home nursing	.07	.09	.17	.22
5. Laboratory, medicines, and appliances	.48	.56	.60	.71
6. Research and education	.01	.02	.10	.14
	Percentage distribution			
Total	100.0	100.0	100.0	100.0
1. Physicians' services	50.6	49.9	41.7	41.0
2. Hospital services	25.1	27.4	24.0	26.3
3. Dental care	10.4	10.2	18.3	18.0
4. Home nursing	1.7	1.7	3.1	3.0
5. Laboratory, medicines, and appliances	11.9	10.4	11.0	9.8
6. Research and education	.3	.4	1.9	1.9

[1] See footnote 1, table A.

[2] These figures have been rounded. See appendix table 5 for more precise figures.

NOTE.—For the assumptions and premises underlying these illustrative costs, see the text and appendix of this memorandum and the 1946 report (footnote 2).

TABLE C.—*Summary of illustrative health-insurance costs for labor-force coverage* [1]

[At the price and income levels of 1945–46 and late 1948]

[In billions of dollars]

Benefit	Initial or early year		195X	
	1945–46 (120,000,000 persons)	Late 1948 (125,000,000 persons)	1945–46 (120,000,000 persons)	Late 1948 (125,000,000 persons)
Total	$3.45	$4.59	$4.66	$6.22
1. Physicians' services	1.75	2.29	1.94	2.55
2. Hospital services	.86	1.26	1.12	1.64
3. Dental care	.36	.47	.86	1.12
4. Home nursing	.06	.08	.15	.19
5. Laboratory, medicines, and appliances	.41	.48	.52	.60
6. Research and education	.01	.01	.09	.12

[1] See footnote 1, table A.

[2] Based on per capital costs shown in table A and rounded.

NOTE.—For the assumptions and premises underlying these illustrative costs, see the text and appendix of this memorandum and the 1946 report (footnote 2).

APPENDIX A

In 1946 the Bureau of Research and Statistics made available to the Senate Committee on Education and Labor a report[4] on medical care insurance which estimated the initial and early year costs of a fairly complete program of personal health services, covering the entire population, at approximately $4,000,000,000, or $28.76 per capita. For a coverage confined to persons in the labor force and their dependents, the report indicated, initial year costs would be about $3.5 billion, which could be financed by a pay-roll contribution rate of about 3½ percent.

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[4] Medical Care Insurance—A Social Insurance Program for Personal Health Services. Report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, July 8, 1946 (79th Cong., 2d sess.), Senate Committee Print No. 5 (hereafter referred to as the "1946 Report").

These anticipated costs were based on the outlook of late 1945–early 1946 price and income levels. What effect have changes in these levels since then had on the cost figures?

To answer this question three estimates have been prepared. They were:

1. Based on the assumption that costs for each of the six major items of expenditure increased in the same proportion that prices paid for identical or related items increased in the Consumer Price Index of the Bureau of Labor Statistics. This index measures changes in the retail prices of goods and services commonly purchased by moderate-income families living in large cities (table 1).
2. Based on the assumption that costs for the six major items of expenditure increased in the same ratio as did aggregate personal consumption expenditures for these or related items, as estimated by the Department of Commerce (table 2).
3. Based on the assumption that the cost of personal service items (physicians' services, dental care, nursing) increased at about the same rate as total national income, while the cost of hospital services, laboratory services, medicines and appliances increased at about the same rate as the average of retail prices in large cities, as measured by the total value of the Bureau of Labor Statistics Consumer Price Index (table 3).

All three estimates are projections from late 1945–early 1946 costs of a medical-care insurance program as given in the Bureau of Research and Statistics report. They are applicable therefore only to the types of benefits offered under the program described in that report.

A. Benefits to which the cost estimates apply

The benefits to be provided in the initial or early years of the program to which the cost estimates apply are:

1. Physician's services in office, home, and hospital, including both general practitioner and specialist services: The general practitioner services to be provided are those which a legally qualified physician engaged in the general or family practice of medicine gives to his patients, including preventive, diagnostic, and therapeutic treatment and care, and the prescribing of necessary drugs and appliances. Specialist and consultant service will be available on the recommendation of the general practitioner, except as the referral requirement may be relaxed for particular fields of specialization.
2. Hospital and related services: This service covers all necessary in-patient care for acute or semiacute illness in general or special hospitals, including the provision of bed and board; such medical and related services as are customarily furnished by the hospitals of an area as an accepted part of hospital care; general nursing care; special nursing care when essential to the patient's welfare; use of operating and delivery rooms, and provisions of anesthesia services; essential medications, dressings, and other customary supplies; laboratory, X-ray, and related auxiliary services; essential ambulance services. The hospital benefit, at least initially, is limited to 30 to 60 days per annum.
3. Dental care: Initially the program will be confined to a fairly complete program for children and a limited group of services to adults. The services for children comprise emergency care to alleviate pain, extract nonrestorable teeth, and treat acute dental infections; periodic examinations and prophylaxis; care on a planned basis to keep the mouth healthy; treatment of malocclusion when necessary for efficient mastication. The services for adults include examination and diagnosis, prophylaxis, extractions of teeth considered likely to be injurious to general health, and treatment of acute diseases of the teeth and supporting and adjacent structures.
4. Home nursing: This service is defined as bedside nursing care of the sick on the recommendation of the attending physician, limited if necessary either to the type of illness for which care is provided, or to selected population groups (such as mothers and children), or to a maximum number of services per year, or by a requirement of partial payments for the first or for each service in a period of illness.
5. Essential laboratory and related services, and prescribed medicines and applicances for nonhospitalized persons: Laboratory services include chemical, physical, physiological, microscopical, bacteriological, serological, and histological examinations or analyses of body fluids, excretions, tissues, or functional

performances, for the purpose of diagnosis, therapy, or prevention. The term "laboratory services" is intended to include X-ray diagnosis and X-ray and radium therapy. Laboratory services are to be provided only on the direction of the attending physician. Prescribed medicines and related supplies are restricted to those prescribed by physicians, dentists, and other licensed practitioners and which may involve burdensome costs. The classes of prescriptions and supplies comprehended are sera, vaccines, and other immunizing agents; medicines and drugs prescribed for specific chronic diseases or long-continuing conditions; antibiotics; etc. Appliances include eyeglasses, hearing aids, artificial limbs and members, artificial eyes, trusses, surgical corsets, braces, belts, crutches, wheelchairs, and other aids to locomotion.

6. Research and education: This is properly not a benefit but a charge which might reasonably be made upon the medical-care insurance program for the support of research and education. Support could take the forms of grants, stipends and subsidies to professional participants in the insurance system to enable them to take postgraduate or refresher work; grants-in-aid to nonprofit agencies for the expansion of educational and training facilities in fields with personnel shortages and for the training of auxiliary personnel; grants-in-aid to support studies, demonstrations, and experiments.

B. Comparison of changes in total costs between 1945–46 and late 1948

The estimates suggest that the initial year cost of a program covering the estimated civilian population increased from about $4 bililon in late 1945 to early 1946 to $5 billion or $5½ billion in late 1948, an increase of 26 to 36 percent. Per capita costs are estimated to have gone up in this period from $28.76 to somewhere between $35 and $37.50, or from 22 to 30 percent, depending upon the estimate. Total costs increased more than per capita costs because of the growth in population (table 4).

If coverage is limited to persons in the labor force and their dependents, the costs increased from $3½ billion to from $4⅓ billion to $4¾ billion. The contribution rate needed to supply the necessary funds would have amounted to 3.17 percent of aggregate earned income in 1945–46 (based on earnings up to $3,600 a year) and from 2.93 to 3.16 percent in late 1948 (based on earnings up to $4,800 a year). The contribution rate for a program exclusive of dental care and home nursing would have been 2.78 percent in 1945–46 and between 2.58 and 2.80 percent in late 1948[5] (table 4).

A summary of the estimated costs on a total and on a per capita basis are presented in table 5 to permit a comparison of the results of revising the costs by the three methods.

C. Comparison of changes in the estimated cost of individual items

1. *Physicians' services.*—The cost of physicians' services was estimated in the 1946 report at $2.04 billion. The estimate for the same item at late 1948 price and income levels ranges from $2.46 to $2.68 billion (table 5).

The lowest of the 1948 estimates is obtained by use of the Consumer Price Index of the Bureau of Labor Statistics. Between December 1945 and September 1948, according to this index, the fees charged by general practitioners in large cities for office visits, home visits and for obstetrical care moved upward 15.6 percent. Application of an increase of 15.6 percent to $2.04 billion yields $2.36 billion, which becomes $2.46 billion when adjusted for a 4.3 percent growth in population. The total increase, from $2.04 billion to $2.46 billion, is 20.6 percent (table 1).

Almost identical results are secured when the estimate is based on Department of Commerce estimates of changes in personal consumption expenditures. Between 1946 and 1947 expenditures for physicians, in the Commerce series, rose 10.4 percent. Personal consumption expenditure estimates for 1948 have not yet been developed, but in the 1946–47 difference between the rate of increase in national income and if personal consumption expenditures for physicians is assumed to have been true also for 1947–48, then the growth of 25.9 percent in national income from the average of 1945–46 to the third quarter of 1948 would mean a gain of 21 percent in personal consumption expenditures for doctors' services (table 2).

When the increase is calculated, for rough purposes, on the basis of the total gain in national income, namely, 25.9 percent, then the growth in the cost of doctors 'services, adjusted for population growth, would have been from $2.04 billion to $2.68 billion (table 3).

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[5] The 1946 report (p. 154) refers to a contribution rate of 3.0–3.5 percent rather than 2.78–3.17 percent, assuming an estimated contribution base of $100 million. In the present memorandum the contribution base used for late 1945 to early 1946 cost estimate is $109 billion, the average of the reported figures for 1945 and 1946.

The comment may be offered here that the measure sought is the percentage growth in the income of the average physician in private practice. The cost of the physicians' services item, except for about 5 percent set aside for administration, represents payments to doctors. The estimate of cost in the 1946 report was derived by multiplying the number of physicians in private practice by a sum representing the average annual income per doctor under the insurance system in its early years. The average was presumed to be $11,250 (gross) for general practitioners and $22,500 (gross) for specialists, based on prevailing incomes of doctors, adjusted upward to compensate for the larger volume of service expected under health insurance.

The only recent survey of doctors' income is the Medical Economics Survey for the year 1947. This survey established the average (general practitioners plus specialists) at $17,476 ($18,500 for physicians with less than half their income from salary), or 28 percent above the $13,606 in the 1943 Medical Economics Survey. The dollar figures are not relevant for the purpose of this memorandum (because of the bias resulting from exclusion of physicians 65 years and over in the 1947 survey) but the 28-percent increase between 1943 and 1947 may be pertinent. Since it is likely that doctors' incomes rose more rapidly in the 4-year period 1943–47 than in the 3-year period late 1945–late 1948, the 28 percent may be taken as an outside limit for the increase in payments to physicians since the publication of our 1946 report. It is, as a matter of fact, higher than the increase as estimated by two of the three methods used in the present memorandum.

The estimated costs of physicians' services at late 1948 price and income levels would permit an average payment of $13,000 to $14,135 (gross) per general practitioner, and $26,000 to $28,270 (gross) per specialist to the estimated 138,000 physicians in private practice in the country. The Medical Economics Survey puts at 40 percent the relation of business expenses to gross income. (December 1948, p. 58.) Under health insurance this ratio should be lower. If it drops to 30 percent, average net income to general practitioners would be in the range $9,100–$9,900; to specialists, $18,200–$19,800 (table 6).

2. *Hospital care.*—Hospital care costs under the insurance system are estimated to have increased from $1 billion in 1945–46 to somewhere between $1.39 billion and $1.80 billion (table 5).

Of the six items in medical-care insurance costs, hospital care shows the largest variation in the estimates of percentage increase between 1945–46 and late 1948. The range is from an increase of 32.8 percent to one of 79.1 percent.

The latter percentage represents the relative increase in the average daily rate charged for a men's pay ward in hospitals in cities covered by the Bureau of Labor Statistics Consumer Price Index, adjusted for population growth. Of the three services by which changes in the cost of hospital care are measured in this index—men's pay ward, semiprivate room and private room—the men's pay ward seems closest to the type of hospital service contemplated for the medical-care insurance program described in the 1946 report. It is the service therefore used in the 1948 cost estimate developed on the basis of changes in the Bureau of Labor Statistics Consumer Price Index. When applied to a 1945–46 base of $1 billion, the increase of 71.8 percent in the men's pay ward rate yields an estimated cost of $1.73 billion, and $1.80 billion when adjusted for the population difference (table 1).

The increase on the basis of trends in the Department of Commerce estimates of personal consumption expenditures is 46.1 percent, derived by the same method described earlier for the derivation of expenditures for physicians' services. Use of this basis gives an estimated total cost for hospital services of $1.47 billion (table 2).

The lowest of the three estimates is obtained by applying to 1945–46 cost estimates the percent increase in the total Bureau of Labor Statistics Consumer Price Index—32.6 percent. The result, when adjusted for population increase, is $1.39 billion (table 3).

The following observations may be found useful in assessing the significance of these differences:

(*a*) Daily ward rates are generally below hospital per-diem costs. The pressure of mounting costs in recent years may have impelled many hospitals to raise daily ward rates more rapidly than the rate at which total hospital costs were rising. It is quite possible that as a result the margin of difference between actual per-diem cost and daily ward rate is smaller today than it was in 1945–46.

If this is true, the increase in the ward rate overstates the probable increase in hospital care costs.

(*b*) Department of Commerce estimates of personal consumption expenditures for hospital care are based on data supplied by the American Hospital Association on total expenditures by nonprofit hospitals and payments by patients to proprietary hospitals. These totals are more likely than ward rates alone to reflect the magnitude of changes in hospital maintenance costs.

(*c*) The bulk of hospital costs are accounted for by wages and salaries and food purchases, pay roll costs alone comprising 54 percent of the 1947 outlay of non-Federal general and special short-term hospitals reporting to the American Hospital Association. Wages and salaries in the American Hospital Association annual expenditure series increased 50 percent between 1945 and 1947. Food costs went up 47 percent between December 1945 and November 1948 as measured by the Burau of Labor Statistics Consumer Price Index. Since the food component advanced more rapidly than the average for all items making up this index, use of the total index to measure the increase in hospital costs (as in table 3) may understate the increase in such costs. The growth in the Bureau of Labor Statistics Index of men's pay ward daily rates, on the other hand, would seem to overstate the increase. Of the three measures used in tables 1, 2, and 3, that based on Department of Commerce expenditure data, yielding an increase of 46 percent, appears to give results closest to the percentage growth in pay roll and food costs.

(*d*) Further support for the use of the Department of Commerce basis for measuring the increase in hospital care costs comes from the American Hospital Association annual series on total expenditures per patient day in non-Federal general and special short-term hospitals. This average went up from $8.60 in 1945 to $9.39 in 1946 and $11.09 in 1947. Data are not yet available for 1948, but if the monthly trend in average operating expenditures per occupied bed in hospital management is taken as a guide, such costs increased 17 percent between the average of 1947 and October 1948. An increase of 17 percent in the American Hospital Association 1947 average of $11.09 would bring it up to $12.98, or 44 percent above the average per diem costs for the 2-year period 1945–46. The 44 percent compares favorably with the 46 percent obtained by use of the Department of Commerce consumption expenditure series.

The volume of service in general and special short-term hospitals exclusive of Federal hospitals, has averaged 1 day per person in the civilian population. It was 0.997 per capita in 1944, 1.067 in 1945, 0.988 in 1946, and 1.001 in 1947. (Calculated from annual hospital issues of the Journal of the American Medical Association.) Perhaps 15 to 25 percent represents care in excess of the 30-day maximum which the insurance system may wish to set up in the early years of the program (5 to 10 percent if the maximum is set at 60 days). On the other hand, an increase in the volume of hospital care of approximately the same magnitude may be anticipated as a result of the removal of the economic barrier under health insurance. It is reasonable therefore to estimate the amount of hospital care to be expected in the early years of the program at roughly one patient day per year per person in the civilian population. For the population as of October 1948 this would mean 146,000,000 patient days. In relation to the range in estimated hospital costs, this volume of care would permit payments to hospitals of from $9.53 to $12.36 per patient day at the late 1948 price and income levels (table 7).

3. *Dental care.*—The limited program of dental care envisaged in the 1946 Report was calculated to cost about $3 per capita at 1945–46 price and income levels, or $420,000,000 for a civilian population of 140,000,000. The same program at late 1948 price and income levels and for a civilian population of 146,000,000 would entail an expenditure of from $519,000,000 to $552,000,000 (table 5).

An estimate in between these two figures is obtained by use of the percentage increase between December 1945 and September 1948 in fees charged by dentists in large cities for fillings, extractions, and for cleaning teeth, as measured by the Bureau of Labor Statistics Consumer Price Index. The increase was 21.2 percent, which would raise the estimate of $420,000,000 to $509,000,000. An additional increase to $531,000,000 to account for a population growth of 6,000,000 brings the percentage increase to 26.4 percent (table 1).

The lowest of the three figures is derived by use of Department of Commerce estimates of personal consumption expenditures, brought forward to 1948 by the method described earlier; it is 23.6 percent, yielding a cost estimate of $519,000,000 (table 2).

The highest estimate is secured by assuming that dental care costs increased at approximately the same rate as the growth in national income, i. e., 25.9 percent. When adjusted for population growth, the result is $552,000,000 (table 3).

Of the $420,000,000 for dental care costs in the 1946 report, 40 percent or $168,000,000 was estimated to represented salary costs for auxiliary personnel and expenditures for laboratory services, office costs, etc. Sixty percent or $252,000,000 was considered available for payments to dentists. On the basis of an average net payment per dentist of $6,900 (p. 102) this sum would have permitted the use of the full-time equivalent of 36,500 dentists. If the number of dentists is increased in proportion to population growth, the equivalent figure for late 1948 becomes 38,000. Upon the assumption, again, that 60 percent of dental care expenditures would be used for payments to dentists, the estimate of late 1948 net incomes per dentist is in the range $8,200–$8,700 (table 8).

4. *Home nursing.*—A home-nursing program of the scope projected in the 1946 report was estimated to cost 51 cents per capita, or $71,000,000 in all. This sum becomes $86,000,000 to $93,000,000 when converted to late 1948 price and income levels and when account is taken of population growth.

The Bureau of Labor Statistics does not collect information on nursing fees as part of its Consumer Price Index data, but use of the percentage increase in physicians' fees in that index—15.6 percent—would raise the cost of home nursing from $71,000,000 to $82,000,000, with a further increase to $86,000,000 when adjusted for population change (table 1).

The percentage increase based on Department of Commerce estimates of personal consumption expenditures for private-duty nurses, practical nurses and midwives is 22.5 percent, yielding a late 1948 estimate of $87,000,000 for this item (table 2).

If for purposes of rough calculation home nursing costs are assumed to have increased at approximately the same rate as the national income—25.9 percent—the program would cost $93,000,000 when adjusted for population growth (table 3).

The $71,000,000 set aside for home nursing in the 1946 report would have permitted the employment of 10.375 professional nurses, 20,750 practical nurses and 3,335 supervising nurses, at an average annual salary, respectively, of $2,530, $1,600 and $3,460 (p. 114). An allowance for an increase in the number of nurses at the same rate as the growth in population, in relation to a cost estimate of $86,000,000 to $93,000,000, would permit average salaries in late 1948 of $2,940 to $3,175 for professional nurses, $1,860 to $2,010 for practical nurses, and $4,020 to $4,345 for nurse supervisors (table 9).

5. *Labortory services, medicines and appliances.*—This item was estimated in the 1946 report to cost $475,000,000. It included $150,000,000 for laboratory and related services, $100,000,000 for medicines and related supplies, $187,500,000 for eyeglasses and optometric services, and $37,500,000 for hearing aids and other appliances. Estimates of late 1948 costs range from $507,000,000 to $600,000,000 (table 5).

The goods and services in the Bureau of Labor Statistics Consumer Price Index most comparable to those provided by this part of the medical-care insurance program are optometrists' fees, eyeglasses, and prescriptions and drugs, the last being an average for aspirin tablets, quinine, tincture of iodine and milk of magnesia. The mean average of the indexes for this group increased 13.1 percent between December 1945 and September 1948. Application of this increase to the total of $475,000,000 raises it to $537,000,000. When adjusted for population growth, this becomes $560,000,000 (table 1).

Department of Commerce estimates of spending by consumers for drug preparations and sundries, ophthalmic products and orthopedic appliances suggest that such expenditures increased perhaps only 6.7 percent between the average for 1945 and 1946 and the third quarter of 1948. The estimate of the cost of laboratory services, medicines, and appliances based on this increase is the lowest of the three—$507,000,000 (table 2).

The largest estimate—$600,000,000—is obtained by assuming that for rough purposes the cost increased by the average rate of increase in the total Bureau of Labor Statistics Consumer Price Index, the prescription and drug part of the index, and the optometrist fees—eyeglasses part. This average, for the period December 1945–September 1948, was 21.0 percent, yielding $600,000,000 after adjustment for population growth (table 3).

An estimate of the break-down of late 1948 estimated costs, based on the percentage distribution in the 1946 report is presented in table 10.

6. *Research and education.*—The sum set aside in the 1946 report for research and education was 10 cents per capita, or $14,000,000. The comparable cost in late 1948 was $18,000,000 to $19,000,000 (table 5).

D. Changes in cost estimates in relation to contribution base

The 1946 report suggested that the initial year costs of a medical care insurance program limited to persons in the labor force and their dependents could be financed by a 3½ percent contribution rate. The key figures in this estimate were $3,500,000,000 in anticipated costs and a contribution base of $100,000,000,000, the latter representing the earned income of persons in the labor force, not counting earnings in excess of $3,600. With dental care and home nursing benefits excluded, the cost was reduced to $3,000,000,000 and the contribution rate to 3 percent (p. 154).

Subsequently, data became available which indicate that the contribution base to which 1945–46 estimates of costs should be related was somewhat higher than $100,000,000,000. Earned income up to $3,600 in 1945 totaled $103,000,000,000 and in 1946, $115,000,000,000. If, consistent with the method for deriving costs in this memorandum, the 2 years are averaged, the contribution base becomes $109,000,000,000, and the contribution rate needed to finance initial or early-year costs of a labor-force coverage program falls to 3.17 percent, and to 2.78 percent for the benefits exclusive of dental care and home nursing (table 4).

As of late 1948 the contribution base, inclusive this time of earnings up to $4,800, rose to $148,000,000,000. In relation to the three estimates of cost presented earlier, the necessary contribution rate would be within the range 2.93–3.16 percent for all benefits and 2.58–2.80 percent for the benefits exclusive of dental care and home nursing (again, for initial and early years) (table 4).

ESTIMATE OF COST OF MEDICAL-CARE INSURANCE, CIVILIAN POPULATION COVERAGE, LATE 1948 PRICE AND INCOME LEVELS

TABLE 1.—*Estimate based on Bureau of Labor Statistics Consumer Price Index changes, 1945–48*

[Initial or early year costs]

Item	BLS—Consumer Price Index			Annual cost, medical-care insurance (in millions)				
	December 1945	September 1948	Percent increase	December 1945		September 1948 unadjusted[1]	September 1948 adjusted	
				Amount	Percent		Amount [2]	Percent
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Physicians' services	[3] 118.2	[3] 136.2	15.6	$2,040	50.7	$2,358	$2,459	45.0
Hospital services	[4] 138.7	[4] 238.3	71.8	1,007	25.0	1,730	1,804	33.0
Dental care	[5] 121.7	[5] 147.5	21.2	420	10.4	509	531	9.7
Home nursing	(6)	(6)	(7)	71	1.8	[8] 82	86	1.6
Laboratory medicines, and appliances	[9] 109.1	[9] 123.4	13.1	475	11.8	537	560	10.3
Research and education	(7)	(7)	(7)	14	.3	[10] 18	19	.4
Total	(7)	(7)	(7)	4,027	100.0	5,234	5,459	100.0
Per capita	(7)	(7)	(7)	[11] 28.76	(7)	(7)	[12] 37.39	(7)

[1] Application to amounts in column 4 of percent increases in column 3.

[2] Figures in column 6 increased uniformly by 4.3 percent, representing increase in population from 140,000,000 to 146,000,000.

[3] General practitioner fees. Average of office visit fee, home visit fee, obstetrical case fee.

[4] Daily rate for men's pay ward.

[5] Dentists' fees, combined, for fillings, extractions, cleaning teeth.

[6] Not included in Consumer Price Index.

[7] Not applicable.

[8] Increased by percent increase in cost of physicians' services, 15.6 percent.

[9] Mean average, index for optometrists' fees and eyeglasses and prescriptions and drugs.

[10] Increased by percent increase in cost of all preceding items, 30.0 percent.

[11] Assumed population equals 140,000,000.

[12] Assumed population equals 146,000,000 (civilian population Oct. 1, 1948—P–25, No. 17).

Sources: BLS–CPS data from mimeographed releases, "Indexes of Retail Prices of Services and Miscellaneous Goods," October 1947, and Supplement III, issued November 1948. Annual cost of medical-care insurance, December 1945 price and income levels, from I. S. Falk, "Financial Aspects of Medical Care Insurance," Social Security Bulletin, December 1946.

TABLE 2.—*Estimate based on trends in Department of Commerce estimates of personal consumption expenditures for medical care*

[Initial or early year costs]

Item	Personal consumption expenditures: Annual rate (in millions)			Annual cost, medical-care insurance (in millions)			
	1945–46 (1)	Third quarter, 1948 [1] (2)	Percent increase (3)	1945–46		Third quarter, 1948 [2]	
				Amount (4)	Percent (5)	Amount (6)	Percent (7)
Physicians' services	$1,433	$1,734	21.0	$2,040	50.7	$2,468	48.7
Hospital services	[3] 989	1,445	46.1	1,007	25.0	1,471	29.0
Dental care	770	952	23.6	420	10.4	519	10.2
Home nursing	[4] 166	203	22.5	71	1.8	87	1.7
Laboratory, medicines, and appliances	[5] 1,585	1,691	6.7	475	11.8	507	10.0
Research and education	(6)	(6)	(6)	14	.3	[7] 18	.4
Total	(6)	(6)	(6)	4,027	100.0	5,070	100.0
Per capita	(6)	(6)	(6)	[8] 28.76	(6)	[9] 34.73	(6)

[1] Column 1 times column 3. Column 3 derived as follows:

Item	Percent increase 1946–47		25.9 percent [b] times column 2 (3)
	Percent [a] (1)	As percent of increase in national income (2)	
National income	12.9		
Physicians' services	10.4	81	21.0
Hospital services	23.0	178	46.1
Dental care	11.8	91	23.6
Home nursing	11.2	87	22.5
Laboratory, medicines, etc	3.3	26	6.7

[a] Survey of Current Business, July 1948, p. 24.

[b] Percent increase in national income, average of 1945 and 1946 and annual rate in third quarter of 1948 (Survey of Current Business, July 1948, p. 16 and December 1948, p. S–1).

[2] Application to column 4 of increase in column 3.

[3] Privately controlled hospitals and sanitaria.

[4] Private-duty trained nurses, practical nurses, midwives.

[5] Drug preparations and sundries, ophthalmic products and orthopedic appliances.

[6] Not applicable.

[7] Column 4 increased by 25.9 percent, average for all preceding items.

[8] Population equals 140,000,000.

[9] Population equals 146,000,000.

Sources: Department of Commerce data on personal consumption expenditures from Survey of Current Business, July 1948, p. 24; 1945–46 column in table is mean average of 1945 and 1946. Annual cost of medical-care insurance for 1945–46 from I. S. Falk, Financial Aspects of Medical Care Insurance, Social Security Bulletin, December 1946.

Table 3.—*Estimate based on application of increase in Bureau of Labor Statistics Consumer Price Index to selected items, and in national income to other items*

[Initial or early year costs]

Item	Annual cost, medical care insurance late 1945–early 1946 (in millions)		Basis of increase	Estimated percent increase 1945–46 to late 1948	Estimated annual cost, medical care insurance late 1948 (in millions)		
						Adjusted	
	Amount (1)	Percent (2)	(3)	(4)	Unadjusted [5] (5)	Amount [6] (6)	Percent (7)
Physicians' services	$2,040	50.7	Commerce: National income.	[1] 25.9	$2,568	$2,678	50.2
Hospital services	1.007	25.0	Bureau of Labor Statistics Consumer Price Index, total.	[2] 32.6	1,335	1,392	26.1
Dental care	420	10.4	Commerce: National income.	[1] 25.9	529	552	10.3
Home nursing	71	1.8	do	[1] 25.9	89	93	1.7
Laboratory, medicines and appliances.	475	11.8	Bureau of Labor Statistics Consumer Price Index, selected items.	[3] 21.0	575	600	11.2
Research and education.	14	.3	Commerce: National income	[1] 25.9	18	19	.4
Total	4,027	100.0	(4)	(4)	5,114	5,334	100.0
Per capita	$28.76	(4)	(4)	(4)	(4)	36.53	(4)

[1] Percent increase in national income from annual average 1945–46 of $180,510,000,000 to the annual rate of $227,300,000,000 based on the third quarter of 1948.

[2] Percent increase in total index from 129.9 in December 1945 to 172.2 in November 1948.

[3] Mean increase in (1) total index; (2) prescriptions and drugs index: (3) optometrists' fees, eyeglasses index.

[4] Not applicable.

[5] Application to amounts in column 1 and percent increases in column 4.

[6] Figures in column 5 increased uniformly by 4.3 percent, representing increase in population from 140,000,000 to 146,000,000.

Sources: Department of Commerce estimates of national income from Survey of Current Business, July 1948, p. 16, and December 1948, p. S–1. Bureau of Labor Statistics Consumer Price Index from Monthly Labor Review, July 1946, p. 109, and by phone from Bureau of Labor Statistics for Nov. 15. Indexes cited in footnote 3 from sources given in table 1. 1945–46 medical-care insurance costs from source cited in table 1.

TABLE 4.—*Summary of cost aspects and contribution rates, medical-care insurance program, at late 1945-early 1946 and at late 1948 price and income levels*

[Initial or early year costs]

Item	Estimate as of late 1945-early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (commerce)	III (combination)
Population coverage:				
Total civilian population (in millions)	140	146	146	146
Labor force (in millions)[1]	120	125	125	125
Insurance costs (in millions of dollars):				
Total civilian population coverage:				
All insurance benefits	$4, 027	$5, 459	$5, 070	$5, 334
All but dental and home nursing	3, 536	4, 842	4, 464	4, 689
Labor force coverage: [2]				
All insurance benefits	3, 451	4, 673	4, 340	4, 566
All but dental and home nursing	3, 030	4, 145	3, 821	4, 014
Per capita costs:				
All insurance benefits	28. 76	37. 39	34. 73	36. 53
All but dental and home nursing	25. 26	33. 16	30. 58	32. 12
Cost as percent of earned income: Earned income subject to contribution rate (in billions of dollars)	[3] 109	148	148	148
Labor force coverage: cost as percent of earned income: [4]				
All insurance benefits	3. 17	3. 16	2. 93	3. 09
All but dental and home nursing	2. 78	2. 80	2. 58	2. 71

[1] Members of the labor force and their dependents estimated at approximately 85 to 86 percent of total population on the basis of census data.

[2] Total population costs reduced proportionately to difference between total population coverage and labor force coverage.

[3] The 1946 report (p. 154) refers to a contribution rate of 3.0–3.5 percent rather than 2.78–3.17 percent, assuming an estimated contribution base of $100,000,000. In the present memorandum the contribution base used for late 1945–early 1946 cost estimate is $109,000,000,000, the average of the reported figures for 1945 and 1946.

[4] For 1945–46 earnings up to $3,600 per annum; for 1948, earnings up to $4,800 per annum.

Sources: Population and labor force coverage estimates from 1940 census data and subsequent Bureau of the Census releases. Total and per capita costs from tables 1, 2, and 3. Earned income subject to contribution rate estimated by Social Security Administration. Estimate as of late 1945–early 1946 is average of 1945 and 1946.

TABLE 5.—*Summary of estimates of total and per capita costs, medical-care insurance, by type of service, at late 1945, early 1946, and at late 1948 price-and-income levels*

[Initial or early-year costs]

Item	Estimate as of late 1945, early 1946 [1]	Estimates as of late 1948		
		I [2] (BLS-CPI)	II [3] (Commerce)	III [4] (Combination)
	Total costs (in millions)			
Total	$4, 027	$5, 459	$5, 070	$5, 334
Physicians' services	2, 040	2, 459	2, 468	2, 678
Hospital services	1, 007	1, 804	1, 471	1, 392
Dental care	420	531	519	552
Home nursing	71	86	87	93
Laboratory, medicines, and appliances	475	560	507	600
Research and education	14	19	18	19
	Per capita costs			
Total	$28. 76	$37. 39	$34. 73	$36. 53
Physicians' services	14. 58	16. 84	16. 90	18. 34
Hospital services	7. 19	12. 36	10. 08	9. 53
Dental care	3. 00	3. 64	3. 55	3. 78
Home nursing	. 51	. 59	. 60	. 64
Laboratory, medicines, and appliances	3. 84	3. 84	3. 47	4. 11
Research and education	. 10	. 13	. 12	. 13

[1] Social Security Bulletin, December 1946, p. 18.

[2] Table 1.

[3] Table 2.

[4] Table 3.

TABLE 6.—*Physicians' services, in medical-care insurance: Number of doctors providing service, summary of costs, income per doctor*

[Initial or early year; civilian population coverage]

Item	Estimate as of late 1945, early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (Commerce)	III (Combination)
Number of physicians providing service (full-time equivalent)	132,000	138,000	138,000	138,000
General practitioners	92,000	96,000	96,000	96,000
Specialists	40,000	42,000	42,000	42,000
Estimated cost of physicians' services (in millions)	$2,040	$2,459	$2,468	$2,678
Administration (5 percent)	105	123	123	134
Payments to physicians	1,935	2,336	2,345	2,544
To general practitioners	1,035	1,246	1,252	1,357
To specialists	900	1,090	1,093	1,187
Average income per physician	14,660	16,935	16,990	18,435
General practitioners, gross	11,250	13,000	13,000	14,135
Net, assuming 50 percent is net	5,625	6,500	6,500	7,068
Net, assuming 60 percent is net	6,750	7,800	7,800	8,481
Net, assuming 70 percent is net	7,875	9,100	9,100	9,895
Net, assuming 80 percent is net	9,000	10,400	10,400	11,308
Specialists, gross	22,500	26,000	26,000	28,270
Net, assuming 50 percent is net	11,250	13,000	13,000	14,135
Net, assuming 60 percent is net	13,500	15,600	15,600	16,962
Net, assuming 70 percent is net	15,750	18,200	18,200	19,789
Net, assuming 80 percent is net	18,000	20,800	20,800	22,616

Sources: Number of physicians as of late 1945, early 1946 from Medical Care Insurance, p. 40. Estimate as of late 1948 based on late 1945 estimate increased by percentage increase in population (4.3 percent). Estimated total costs from tables 1, 2, 3. Allowance for administration for late 1945, early 1946 from Medical Care Insurance, p. 57; for late 1948, same proportion to total costs assumed, i. e., 5 percent.

TABLE 7.—*Hospital services in medical-care insurance: Patient-days utilized, summary of costs, and average payment per patient-day*

[Initial or early year: Civilian population coverage]

Item	Estimate as of late 1945, early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (Commerce)	III (Combination)
Number of hospital patient-days utilized (in millions)	140	146	146	146
Estimated cost of hospital services (in millions)	$1,007	$1,804	$1,471	$1,392
Average payment per patient-day	$7.19	$12.36	$10.08	$9.53

Sources: Hospital patient-days from population in table 4. 1 day per capita assumed. Cost of hospital services from tables 1, 2, 3.

TABLE 8.—*Dental case in medical-care insurance: Number of dentists providing service, summary of costs, income per dentist*

[Initial or early year; civilian population coverage]

Item	Estimate as of late 1945, early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (Commerce)	III (Combination)
Number of dentists providing service (full-time equivalent)	36,500	38,000	38,000	38,000
Estimated cost of dental care (in millions of dollars)	$420	$531	$519	$552
Payments to auxiliary personnel for lab services, office costs, etc	168	212	208	221
Payments to dentists	252	319	311	331
Average per dentist (net)	6,900	8,400	8,200	8,700

Sources: Number of dentists late 1945, early 1946 estimated from Medical Care Insurance, p. 102. Estimate for late 1945, early 1946 based on assumption of increase in proportion to increase in population (4.3 percent). Estimated total costs from tables 1, 2, 3. Break-down from proportions in Medical Care Insurance, p. 102.

TABLE 9.—*Home nursing care in medical-care insurance: Number of nurses providing service, summary of costs, payment per nurse*

[Initial or early year; civilian population coverage]

Item	Estimate as of late 1945, early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (Commerce)	III (Combination)
Number of nurses providing service (full-time equivalent)	34,460	35,935	35,935	35,935
Professional	10,375	10,820	10,820	10,820
Practical	20,750	21,640	21,640	21,640
Supervisory	3,335	3,475	3,475	3,475
Estimated cost of home nursing (in millions)	$71	$86	$87	$93
Average payment per nurse:				
Professional	2,530	2,940	2,970	3,175
Practical	1,600	1,860	1,880	2,010
Supervisory	3,460	4,020	4,065	4,345

Sources: Number of nurses in late 1945, early 1946, from Medical Care Insurance, p. 114, reduced to fit estimated cost for late 1945–early 1946. Estimates of nurses for late 1948 based on increase proportional to increase in population (4.3 percent). Estimated total costs from tables 1, 2, 3. Average payment per nurse, late 1945–early 1946, from Medical Care Insurance, p. 114. Averages for late 1948 increased in proportion to increase in total estimated costs, adjusted for increase in number of nurses.

TABLE 10.—*Laboratory services, medicines and appliances in medical-care insurance: Summary of costs*

[Initial or early year; civilian population coverage]

[In millions of dollars]

Item	Estimate as of late 1945, early 1946	Estimates as of late 1948		
		I (BLS-CPI)	II (Commerce)	III (Combination)
Total	475	560	507	600
Laboratory and related services	150	177	160	190
Medicines and related supplies	100	118	107	125
Orthopedic and prosthetic appliances	225	265	240	285
Eyeglasses and optometric services	187.5	221	200	237
Other	37.5	44	40	48

Sources. Total costs from tables 1, 2, 3. Break-down for late 1945, early 1946, from Medical Care Insurance, p. 129. Break-down for late 1948 based on late 1945.

FEDERAL SECURITY AGENCY,
DIVISION OF RESEARCH AND STATISTICS,
SOCIAL SECURITY ADMINISTRATION,
May 1949.

A COMPARISON OF (A) ACTUAL PERSONAL EXPENDITURES FOR MEDICAL CARE, AND (B) ESTIMATED DISBURSEMENTS UNDER NATIONAL HEALTH INSURANCE AT 1945–46 PRICE AND INCOME LEVELS

INTRODUCTORY NOTES

Many inquiries request data that will be useful in comparing the amounts ordinarily paid for various kinds of medical services and the amounts that would presumably be paid for the same kinds of services under a national system of health insurance. The attached table was prepared to answer such inquiries.

It is not possible to make an exact comparison of current and proposed expenditures. Current personal expenditures contain items that may not be included within a health-insurance budget; and vice versa. The table is therefore only roughly indicative of what a more precise comparison might show.

The comparison must, of course, use data which apply to the same time period—or to closely adjacent time periods—so that they do not involve substantial differences in price and income levels. The estimates for health-insurance costs which are available for such a comparison reflect the late 1945 early 1946 price and income levels and outlooks. They are therefore compared in the attached table with the average of personal-consumption expenditures in the two calendar years 1945 and 1946.[1] [2]

Current-expenditure data for medical care are based on actual reporting and sampling, and are therefore factual to the extent that the methods result in data that correctly reflect the current national picture. Estimates of expenditures under a system of national health insurance, on the other hand, are based on assumptions and premises as to specifications of an insurance system. Since such cost estimates have little meaning apart from the assumptions and premises on which they are based, the reader is referred to the source document for more detail than is summarized here.[3]

The health-insurance estimates take into account that expenditures under the insurance system will increase after it has been in operation for some years—after effective public demand for services has increased, shortages of physicians, dentists, nurses, and other personnel have been met, and needed hospitals and other facilities have been built. Two sets of annual cost estimates were therefore developed, one applying to an "initial or early year" of insurance operation and the other to a year 5, 10, or 15 years later and called 195X. Both sets of estimates are shown in the table.

All columns in the table exclude public expenditures financed out of general revenues for public health, for services furnished to the armed forces and veterans,[4] for mental and tuberculosis institutions, etc.

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[1] For health insurance cost estimates: Medical Care Insurance: A Social Insurance Program for Personal Health Services. A report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, United States Senate, 79th Cong., 2d sess., Senate Committee Print No. 5, July 8, 1946, 185 pp.

[2] For personal consumption expenditures: Survey of Current Business (Department of Commerce), July 1948, p. 24.

[3] The health-insurance cost estimates were developed in late 1945 and early 1946 and were intended to indicate costs at then current and prospective price and wage levels. OPA was abolished a few months after the estimates were completed: price and wage levels moved up to a higher level; and the cost estimates became obsolete—so far as current or immediate prospective dollar amounts were concerned. However, since wages and other earnings have increased roughly in the same proportions as prices, the obsolescence of the dollar estimates does not apply to costs measured in percentages of earnings, the basis assumed in the 1946 study for financing the insurance system. A comparison at 1948 levels would show approximately the same relationships as those found for 1945–46, since both sets of figures (actual expenditures and estimated insurance costs) have increased similarly. A comparison at 1948 levels will be prepared when detailed personal-expenditure data are available for that year .

[4] Federal general-revenue expenditures for hospitals are not included in the personal-consumption expenditures; and services in Federal hospitals are not included in the health-insurance cost estimates. Under health insurance there could be some shift of veterans' hospitalization practices, especially for non-service-connected cases, so that relatively more such service would come within the scope of health-insurance costs and relatively less would remain outside the insurance system. To the extent that this happened, the costs of the insurance system would be increased; but the increase would be offset by reduction in Federal general-revenue expenditures for hospitalization.

The estimated insurance expenditures are shown here as if they applied to a whole population. This is done not because the insurance coverage is assumed to be national, but only so that the data will be comparable in this respect with the personal-consumption-expenditure figures which apply to a whole population. The health-insurance aggregates shown in the table are the estimated per capita costs multiplied by 140 million.[5] It is recognized that a health-insurance program may be limited initially so that it applies not to a total population but to the persons in the labor force plus their dependents (about 85 percent of the population) or to some other coverage which is less than total.

For complete details concerning the data see the source documents. For summary explanatory notes see the appendix to this memorandum.

GENERAL DISCUSSION OF THE COMPARISON

A health-insurance program which would provide 100 percent population coverage is estimated to cost initially about 4 billion dollars at 1945–46 price and income levels, about 1.3 billion dollars less than the total actual personal consumption expenditures for medical and related services in the same period. Although providing for greater expenditures for some items, the lower aggregate amount of the health-insurance estimate is chiefly due to the fact that (*a*) nothing comparable to the $350,000,000 shown as actual expenditures for group-insurance overhead and for secondary or sectarian practitioners is included in the health-insurance program, and (*b*) the amount to be spent on auxiliary services (medicines, appliances, and laboratory services) is more than $1,000,000,000 lower than the actual expenditures cited for these items. The health-insurance expenditures are concentrated on medical and hospital services, with only limited provisions for the other types of services and commodities currently purchased by the civilian population through personal expenditures.

The amount indicated as the probable disbursement to physicians in an initial or early year of a health-insurance program is about 40 percent greater than the actual personal-consumption expenditures shown for the same class of service; the actual expenditures for this item include some personal disbursements for laboratory services, shown separately in the health-insurance estimate. The difference in the two amounts comes about partly because more physician's services per capita are assumed in the insurance estimate, and because physicians would not be called on to provide services without remuneration for the insured population. They would receive payments through the insurance system for the medical care they provide.

The amount estimated for payments to all hospitals under the insurance system is approximately the same as the total personal-consumption expenditures for hospitals as recorded in the Department of Commerce document. However, the Department of Commerce series is confined to expenditures in "privately controlled hospitals and sanitariums and proprietary hospitals" and omits over $100,000,000[6] in income received from patients by municipal or other Government-controlled (non-Federal) general and special short-term hospitals. But the insurance estimate applies only to hospital services at ward or multiple-bed accommodation levels and is exclusive of services in excess of 60 days in a year and of out-patient services; the personal-consumption expenditures include stays of all duration, in all kinds of accommodations, income from out-patient services, and amounts spent privately for laboratory work, shown elsewhere in the insurance estimate.

The insurance figure would have permitted, for ward and multiple-bed accommodations, an average payment of $7.19 per patient-day at the 1945–46 levels. Hospitals would have been entitled, in addition, to supplementary payments from patients for private-room care and for services beyond the 60-day maximum, and from the insurance system for out-patient services.

Estimates of insurance expenditures for dental care and for home nursing are considerably lower in the initial or early years than actual expenditures for these items because of the limitations placed on the amounts of such services in the initial insurance program. The probable future size of the insurance expenditures—exceeding the actual expenditures for 1945–46—can be noted in the column showing the estimates for a later year (195X).

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[5] See p. 147 of the source document (reference No. 1). The calculations used the per-capita figures which assume a minimum-service benefit for hospital care.

[6] Calculated from data on p. 10 of a Report and An Analysis of the Information Developed from AHA Directories, December 1948. Federal Security Agency, Public Health Service, Division of Hospital Facilities, Office of Hospital Facilities, 56 pp.

Actual expenditures for drug preparations, prescriptions, and sundries are more than 12 times as high as the initial insurance estimates, because of the limitations put on these items in the estimated insurance costs. The actual expenditures include many prescribed and self-prescribed medicines, and many home remedies, which were excluded from the insurance estimates.

The expenditure estimated for ophthalmic products (eyeglasses, etc.) and orthopedic appliances are lower under the insurance program, mainly because the insurance assumptions allowed only for supplies and services purchased on professional prescription and for those needed for medical reasons—and do not allow for additional costs resulting from personal inclinations as to style, cosmetic and aesthetic values, etc.

For further details about the various items, and for a discussion of the 195X insurance cost estimates, see the appendix notes.

Comparison of actual expenditures for medical care with estimated expenditures under national health insurance (at comparable price and income levels)

[In millions of dollars]

Item	Personal consumption expenditures (actual) 1945-46 averages [1] (A)	Health-insurance expenditures (estimate)	
		Initial or early year [2] (B)	Later year [2] (195X) (C)
Total	[3] $5,298	$4,027	$5,450
Physicians' services	1,433	2,040	2,265
Hospital services	[3] 989	1,007	1,309
Dental care	770	420	998
Nursing services	166	71	174
Medicines, appliances, and laboratory	1,585	475	600
1. Drug preparation and sundries	1,225	100	150
2. Ophthalmic products and orthopedic appliances	360	225	225
3. Laboratory	(4)	150	225
Osteopathic physicians, chiropractors, chiropodists, and podiatrists, and miscellaneous healing and curing professions	194		
Net payments (overhead and unexpended balance) to:			
1. Group hospitalization and health associations	51		
2. Accident and health insurance, mutual accident and sick benefit associations [5]	107		
Student medical fees	3		
Research		14	104

[1] Survey of Current Business (Department of Commerce), July 1948, p. 24.

[2] Medical Care Insurance: A social-insurance program for personal health services. A report from the Bureau of Research and Statistics, Social Security Board, to the Committee on Education and Labor, U. S. Senate, 79th Cong., 2d sess.; Senate Committee Print No. 5, July 8, 1946, 185 pp. "195X" represents a year 5, 10, or 15 years after the program goes into operation.

[3] Does not include about $100,000,000 spent by patients in Government-controlled (non-Federal) general and special hospitals.

[4] Included in this series either under physicians or hospitals.

[5] Reduced to one-third the amount shown in the source document in order to omit estimated administrative expenses for cash sickness or wage-loss indemnity, death benefits, etc., which are included in the published figures but have no comparable representation in the estimated costs of health insurance.

APPENDIX

Supplementing the preliminary comments and general discussion which preceded the table, this appendix contains more detailed explanations of the comparisons. Each class of service is considered under the three subheadings:

A. Personal consumption expenditures (actual) (from the Department of Commerce series).
B. Health-insurance expenditures (estimated)—initial or early year.
C. Health-insurance expenditures (estimated)—195X.

For the sake of brevity, the three corresponding subheadings are abbreviated to: "A. 'Actual,'" "B. 'Insurance estimate—early year,'" and "C. 'Insurance estimate—195X.'"

All three expenditure columns in the table are based on approximately—though not precisely—the same population. The population of the United States on January 1, 1946, was 140.4 million; but 6.6 million were in the armed services, with 3.6 million overseas. Thus, the personal-consumption expenditures shown in the table apply to a 1945–46 civilian population with a midpoint of 133.8 million—6.2 million less than the 140 million used for the insurance estimates in the table. The actual expenditures incurred by the population for civilian medical care may not have been greatly reduced by the absence of those who were members of the armed forces, because these were largely young, healthy adults.

Both the initial or early year insurance estimates and those for 195X are based on an assumed civilian population of 140 million. The population was kept at this figure for the 195X estimate to avoid introducing another variable into the comparison.

Physicians' services

A. "Actual."—Derived from the gross receipts which medical practitioners in independent private practice received from individuals. It includes receipts from prepayment medical-care insurance and any money received from claims for health, accident, or sickness which were then spent by individuals or groups for medical care furnished by physicians. It also includes expenditures for X-ray and general laboratory services when rendered under private (not hospital) auspices.

B. "Insurance estimate—early year."—Calculated on the basis of the total number of physicians available to serve insured persons and the gross incomes which the expected patient-loads should yield to the practitioners by reference to customary incomes earned without insurance. Costs of X-ray and laboratory services under private auspices are not included here. The scope of services includes general practitioner and specialist services. The estimate includes services of physicians, etc., in out-patient departments of hospitals as well as in clinics.

The 1946 figure was based on an estimate that 92,000 general practitioners and 40,000 specialists (both figures on a full-time or man-year basis) would provide the required medical services. Five percent of this item was set aside for administrative expenses. The balance yields average gross incomes amounting to $11,250 for general practitioners and $22,500 for specialists, with net incomes presumably 30 to 40 percent less than the gross. These figures are at 1945–46 price and income levels and, it may be emphasized, they are averages; the incomes of individual practitioners (other than those who choose to be paid by salary) would depend on the number of insured persons who choose them, the amount of service they provide, etc.

C. "*Insurance estimate—195X.*"—The increase of about 11 percent over the initial-year figure assumes a ratio of one general practitioner to 1,250 persons instead of the 1:1,500 ratio used for the initial or early years. No change was assumed in the ratio for specialists.

Hospital services

A. "*Actual.*"—Based on the operating expenditures of nonprofit privately controlled hospitals and sanitariums plus the payments made by patients to proprietary hospitals. The figure includes payments by Blue Cross and other prepayment groups for such hospitalization, and covers all hospitalization regardless of duration. It includes the cost of operating the out-patient departments. It does not include private expenditures in publicly controlled institutions such as municipal hospitals and tuberculosis institutions and is therefore somewhat understated. In 1946 such expenditures by patients in Government-controlled, non-Federal, general and special short-term hospitals probably amounted to about $100,000,000, exclusive of payments to tuberculosis and mental institutions.

B. "*Insurance estimate—early year.*"—Based on an expectation of an average of 1 day of hospital care per person covered (140,000,000) at rates which would be high enough to cover the hospitals' actual costs of operation of the in-patient departments. Limitations on the amount of hospitalization to 60 days in a year is assumed, with further limitations (30 days after diagnosis) for mental and tuberculous cases in general and special hospitals. The data exclude care in mental and tuberculosis institutions, but include other types of care in publicly owned (non-Federal) general and special hospitals.

The hospitals would derive additional income from patients who choose a private room when such was not considered essential to recovery, from those who needed more than 60 days' care in any 1 year, and as payment for out-patient services. (See Physicians' Services.)

C. *"Insurance estimate—195X."*—Increase of 30 percent assumes an increase from an average of 1 to an average of 1.3 days of care per person.

Dental care

A. *"Actual."*—Derived in the same fashion as the figures for expenditures for physicians. Includes expenditures for the services of private laboratories doing dental work and such personnel as dental hygienists, receptionists, etc., which are part of the gross expenditures for dental services.

B. *"Insurance estimate—early year."*—Considerably lower than current actual expenditures because of the initial limitations placed on the scope of insured dental services, due to shortages of dental personnel and the recognition of the volume of accumulated neglect which cannot be met directly with the present supply of dentists. The program would include as complete service for children as could be provided, and limited services for adults. The estimates cover laboratory services and other items of overhead related to the services contemplated.

Dentists would continue to receive income from private patients for categories of service not included in the initial benefits.

C. *"Insurance estimate—195X."*—Expanded scope of insured dental services is contemplated as more personnel becomes available. This will take some years to achieve, because of the length of time required for the training of dental personnel.

Home-nursing services

A. *"Actual."*—Includes direct expenditures for nursing care furnished by private-duty and practical nurses and by midwives, and the value of meals they received.

B. *"Insurance estimate—early year."*—Lower than current actual expenditures because of the limited scope of the benefits in the initial and early insurance years, necessitated by the shortage of nursing personnel. Limitations of service might be by type of illness or for selected population groups, or on the amount of service for which the insurance system would pay.

C. *"Insurance estimate—195X."*—Expanded scope of home-nursing benefit when shortages of personnel have been overcome. Anticipates an average of one nursing visit per capita per year. Expansion of this benefit can be achieved earlier than complete dental benefits, because the training period is shorter for nurses than for dentists.

Auxiliary services

1. Drug preparations and sundries

A. *"Actual."*—Actual expenditures came to about 1.25 billion dollars for so-called nondurable commodities and increased self-determinated needs for these items as well as prescriptions.

B. *"Insurance estimate—early year."*—Very much lower than curren expenditures (1945–46) because the insurance expenditures have been limited to prescriptions which are unusually important or unusually expensive (e. g., sera, vaccines and other immunizing agents, antibiotics, and medicines purchased for specified chronic diseases, such as diabetes). The cost of most drugs and home remedies, whether regarded as medically essential or not, is not burdensome and was not regarded as needing insurance protection. There would thus be a continuing amount spent directly by individuals for prescribed and nonprescribed medicines, home remedies, etc., not included in the insurance benefit.

C. *"Insurance estimate—195X"*.—Increased 50 percent over the amount included for an initial or early year. After experience has been gained by actual administration of this benefit, it was assumed that these provisions might be liberalized to this extent, and also increased to match the expected increase in physicians' services.

2. Ophthalmic products and orthopedic appliances

A. *"Actual"*.—Includes many items bought both on prescription or as a result of self-diagnosis.

B. *"Insurance estimate—early year"*.—Would be purchased on the direction of the physician or other qualified practitioner, since the items included are those essential to care or rehabilitation. They include artificial limbs and eyes, surgical corsets, braces, crutches, wheel chairs, and the like. They also include hearing aids and eyeglasses, and expenditures would cover such professional services as those of optometrists, etc.

The differences in the two figures (A and B) would stem largely from the fact that the insurance estimate is confined to medically prescribed and expensive appliances and would provide durable types of equipment, but only the costs necessary for medical—as distinguished from cosmetic and aesthetic—reasons.

C. "*Insurance estimate—195X*".—No increase is contemplated in this item for the (assumed) fixed population, because the catch-up on accumulated neglect for this type of durable commodities offsets expected expansion.

3. Laboratory and other auxiliary services

A. "*Actual*".—Laboratory and X-ray services were included with actual expenditures for physicians, hospitals, or dentists. Other auxiliary services, such as chiropodists and physiotherapists, are included in this column in the next item.

B. "*Insurance estimate—early year*".—Includes expenditures for diagnosis, therapy, or prevention. Would include X-ray diagnosis, and X-ray and radium therapy. The services are to be provided upon direction of the attending physician; they may include physiotherapy and other services.

C. "*Insurance estimate—195X*".—Increased 50 percent to take care of increased services required as the demand for medical care increases. Experience would show in what areas laboratory services could be expanded.

Miscellaneous secondary and sectarian practitioners

A. "*Actual*".—The figure shown in the table is a composite of four items listed separately in the source document under "Personal consumption expenditures for medical care." These include item 5, "Osteopathic physicians"; item 6, "Chiropractors"; item 7, "Chiropodists and podiatrists"; and item 10, "Miscellaneous healing and curing professions." They have been grouped in the table because the comments under B apply to all of them.

B. "*Insurance estimate—early year*".—No specific expenditures under this heading were included in the health-insurance estimates. To the extent that osteopaths are licensed physicians, expenditures for their services would be included under "Physicians." Other services from qualified and licensed practitioners would appear under "Medicines, appliances, and laboratory." Individuals would be free to patronize other practitioners at their own expense, as at present.

C. "*Insurance estimate—195X*".—Comment under B applies.

Net payments to group hospitalization and health associations, sickness and accident insurance funds (overhead and unexpended balance)

A. "*Actual*".—The amount shown as net payments to "1. Group hospitalization and health associations" is a net figure based on premiums and dues minus claims paid. It therefore represents overhead and unexpended premiums and dues after benefits have been deducted. Claims paid were included in the amounts for physicians and for hospital services when these benefits were use for these purposes.

The published figures for net payments to "2. Accident and health insurance, mutual accident and sick benefit associations" have been reduced by two-thirds (215,000,000), the proportion of such insurance estimated to cover the overhead for cash sickness, wage loss, death benefit, and other portions of such insurance not comparable to the benefits of a health-insurance program. The remaining one-third, $107,000,000, is the best estimate available of the probable proportion of such insurance net amounts which would be reflected in the benefits of a health-insurance program.

B. "*Insurance estimate—early year*".—This item, which under actual expenditures represents overhead, is not necessary in the estimated expenditures because each of the preceding items has included an allowance for cost of administration.

Since the suggested health-insurance benefits would not be wholly comprehensive in the early years, it is assumed that voluntary insurance might continue to be used to supply some supplementary benefits, such as the cost of private rooms in the hospitals, care in hospitals beyond 60 days per annum, etc., for those who wish to insure privately against such costs.

C. "*Insurance estimate—195X*".—The comment under B applies, except that insurance benefits would be more comprehensive and the need for supplementary insurance would have been further reduced or abolished.

Student medical fees

A. "*Actual.*"—The bulk of these expenditures was made by college and university students.

B. "*Insurance estimate—early year.*"—This item does not appear here because these figures were calculated on the assumption that the insurance program would apply to the whole population. It would still be present as an individual expense under a health-insurance program limited to the labor force and its dependents, since coverage may stop for able-bodied persons at age 18 (the college entrance age), unless they become part of the labor force sufficiently to qualify for insurance benefits.

C. "*Insurance estimate—195X.*"—Comment under B applies.

Research and education

A. "*Actual.*"—No expenditures could be isolated for this item although their existence in fact is recognized. They would be found as part of the total expenditures of such enterprises as the voluntary health agencies, gift-granting foundations, colleges, and universities, private donors, etc., in their educational campaign funds, research underwritings, etc.

B. "*Insurance estimate—early year.*"—This expenditure is not a personal or individual benefit, but more properly a charge on the program which would take various forms. It would be used for necessary research regarding the program, to promote the expansion of training facilities, studies and demonstrations, to pay stipends to practitioners taking refresher or postgraduate courses, etc.

C. "*Insurance estimate—195X.*"—Originally set at an arbitrary amount of $10,000,000 a year, this has again been arbitrarily placed at 2 percent of the total cost of the program in 195X.

SOME STATEMENTS AND MISSTATEMENTS ABOUT NATIONAL HEALTH INSURANCE

1. Is health insurance "socialized medicine"?

Opponents of national health insurance say:

"The proposals * * * are in reality state medicine. If enacted into law and made fully effective, they would destroy the private practice of medicine and dentistry in the United States" (National Physicians Committee, Political Medicine, p. 13).

"We are fully convinced that compulsory prepaid health insurance is definitely socialistic" (hearings before Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 2, p. 106, testimony of Dr. H. F. Connolly).

The truth is:

President Truman in his message to Congress, November 19, 1945, said: "This is not socialized medicine * * * Socialized medicine means that all doctors work as employees of Government. The American people want no such system. No such system is here proposed."

Senator James E. Murray, a sponsor of the national health-insurance bill (S. 1679), said: " 'Socialized medicine' * * * is a loose phrase, loosely used for 'smear' purposes. * * * Intelligent, literate minds define socialized or state medicine to mean that the Government owns and operates all hospitals, and that practicing physicians are employed by the Government on a salary basis—that is, are Federal employees under Government control.

"No such system is or has ever been proposed by those of us advocating national health insurance" (To Your Health, by Senator James E. Murray. The Progressive, February 1949).

Elder statesman Bernard Baruch declared: "There is no question—the need for more medical care exists * * * Nothing has been suggested so far, which promises success, other than some form of insurance covering these people by law and financed by the Government, at least in part—what some would call compulsory health insurance. * * *

"It can be devised, adequately safeguarded, without involving what is termed 'socialized medicine.' I do not fear Government taking its legitimate part in medicine, any more than I fear it in education or housing * * *" (from Mr. Baruch's address at a dinner in New York City, November 19, 1947, sponsored by the Medical Society of the State of New York and two other professional societies).

2. *Free choice of physician*

Opponents say:

"The right of the citizen to pick his own doctor will be wiped out" (National Physicians Committee pamphlets).

"There would be definite limitations in the free choice of physicians and specialists" (testimony of Dr. Hubbard T. Buckner, Washington State Medical Association, Hearings Before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 4, p. 2086).

The truth is:

The proposed health-insurance bill specifically assures the patient the right to choose and change his doctor. Actually, the people woud have freer choice than most of us have today, because choice of doctor will not be limited by inability to pay.

President Truman, in his message to Congress, April 22, 1949, said: "Health insurance is a method of paying for medical care. It will not require doctors to become employees of the Government. It will not disturb the freedom of doctors and hospitals to determine the nature and extent of treatment to be given. It will not interfere with the personal relationship between doctor and patient. Under such a plan, patients will remain free to chose their own doctors, and doctors will remain free to accept or reject patients. Moreover, patients, doctors, and hospitals will remain free to make their own arrangements for care outside the insurance system if they so choose.'

The national health-insurance bill (S. 1679) says: "Every individual eligible for personal health services available under this title may freely select the physician, dentist, nurse, medical group, hospital or other person of his choice to render such services, and may change such selection" (S. 1679, a bill to provide a program of national health insurance and public health. * * * sec. 703, p. 107).

3. *"Bureaucratic control" of doctors*

Opponents say:

"* * * doctors would be subject to bureaucratic control and would be responsible to nonmedical persons. A system of bureaucracy would fasten itself to the medical profession like the old man of the sea and would impose all kinds of senseless rules and regulations" (Walch, J. W., On the Witness Stand, in Free Medical Care, edited by Clarence Peters, 1946, p. 307).

"* * * will subject to bureaucratic control and supervision the ultimate and confidential relationship between doctor and patient" (American Bar Association in Voluntary versus Compulsory Health Insurance, AMA, 1946, p. 81).

"It makes mere political pawns of doctors, dentists, and nurses" (Dr. A. R. Foss, in Hearing Before Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 4, 2106).

The truth is:

The national health-insurance bill assures professional freedom to doctors. Their medical work is not to be subject to lay direction. Doctors are represented on all commissions and advisory councils. All purely medical matters are to be settled only by doctors.

United States Attorney General Thomas C. Clark gave the following opinion in a letter to Senator James E. Murray, May 14, 1946: "I have found nothing in the legal construction of the proposed legislation which would operate to threaten the dignity of the doctor and patient relationship, lessen the desirable effectiveness of medical ethics, or in any way prove prejudicial to either the profession or the public" (Hearings Before Senate Committee on Education and Labor, 79th Cong. on S. 1606, pt. 4, p. 2043).

4. *"Bureaucracy"*

Opponents say:

"It is also to be noted that in the experience of Europe, there will be an employee of the system, outside the field of the actual delivery of medical service for at least every 100 persons insured." Thus in the United States (if there were 100,000,000 people insured) there would be 1,000,000 employees needed (Crownhart, J. G., Sickness Insurance in Europe, supplement to the Wisconsin Medical Journal, vol. 37, No. 10, October 1938, p. 13. See also Hearings Before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 4, p. 2216).

The truth is:

This figure is a gross untruth. The number of administrative employees in the well-established European systems is about 1 to every 2,000 insured persons.

This would mean 50,000 employees if 100,000,000 people were covered by health insurance (Hearings Before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 4, pp. 2205, 2217).

Only a small proportion of these Government employees would be Federal. Most would be local.

5. Cost of health insurance

Opponents say:

"From the beginning the cost of such a system (compulsory health insurance) would amount to between 7 and 8 percent of the worker's income * * * that would be a load of 7,000,000,000 by 1960" (Elizabeth Wilson, Letter to New York Herald Tribune, January 7, 1947).

The truth is:

This figure confuses the cost of health insurance with the cost of all social-security benefits (old-age insurance, etc.).

The best estimates are about $12,000,000,000 for the total social-security program, including the present taxes, not in addition to them.

As for national health insurance, the correct cost figure is 3 percent divided equally between the employer and the employee plus a Federal contribution which is limted to 1 percent of the costs.

This would mean a total amount of about $5,500,000,000 for the first year of operation, or about $37.39 per capita population (Soule, George, the Costs of Health Insurance, prepared and published under the auspices of the Committee on Research in Medical Economics, Inc., New York, and the Public Affairs Institute, Washington, D. C., April 1949, p. 8).

The amount would vary with wage scales and employment levels, but, nevertheless, this $5,500,000,000 does not show a "tremendous added new expenditure." We spend about the same amount now on physicians and hospital care.

People now spend on an average of 3 percent of their income for physician and hospital services. These would be provided under the health-insurance bill, and therefore the health-insurance payments would simply be a substitute for these present expenditures (I. S. Falk, the Financial Aspects of Medical Care Insurance, Social Security Bulletin, December 1946, vol. 9, No. 12, p. 23).

6. Administrative costs compared

Opponents say:

"Insurance companies can insure more efficiently than the Government" (statement by Dr. Morris Fishbein, quoted by Katherine Clark, Insurance Companies and the Wagner Bill, Medical Care, November 1943, p. 309).

"In no instance will the cost of such voluntary prepayment medical care approach the great cost which a Federal plan of socialized medicine or political medicine demand" (McCormick, E. G., in Voluntary versus Compulsory Insurance, American Medical Association, 1946, p. 11).

The truth is:

These statements are exactly the reverse of the truth. The policies sold by private insurance companies to individuals pay back to the policyholder an average of only 50 cents on the dollar, or less, for the premiums paid.

Policies sold to employed groups pay back a larger portion, but usually only between 60 and 75 cents for the premium dollar.

In other words, the best that insurance companies can do is to show an administrative cost, including profits, of at least 25 percent. One of the reasons for this high cost is the necessity of maintaining a sales force to get and keep business in competition with other companies.

Many nonprofit voluntary insurance plans operate at a 12 to 15 percent ratio. Governmental plans, which do not have to maintain any sales force, can operate at half this ratio, or less. The over-all administrative costs of the national health insurance are calculated to be 5 to 7½ percent. Most of the expenditures for administration would be State and local rather than Federal (Medical Care Insurance, p. 146. Report from the Social Security Board to the Committee on Education and Labor, U. S. Senate, Committee Print No. 5, July 8, 1946. S. 1679, 81st Cong., 1st sess., 1949, p. 152).

7. Does health insurance increase sickness?

Opponents say:

The following puotation has been lifted out of text from the writings of an advocate of national health insurance and used as an argument against it:

"The most startling thing about insurance countries is the steady and fairly rapid increase in the number of days the average person is sick. In the United States, average recorded sickness per individual is 7 to 9 days a year. It is nearly twice that among the insured of Great Britain and Germany and has practically doubled in both countries since inauguration of insurance. It seem to be a safe conclusion that insurance has certainly not reduced sickness" (Wright, Michael, Socialized Medicine—Bad Medicine for you! Better Homes and Garden, January 1947).

The truth is:

It is not the days of sickness that increase. It is the days of treatment. Many illnesses had gone untreated formerly whereas under insurance they are given medical treatment in time, often preventing fatal consequences.

In these insurance systems the period for which benefits are given has been extended from time to time—therefore it was inevitable that the number of recorded days of incapacity for which cash sick benefit was paid would increase, not because there was more sickness, but merely because cash benefit would be paid for a larger part of the period of illness and incapacity (Sigerist, Henry E., European Experience in Medical Organization, American Academy of Political and Social Sciences, 1934, p. 37).

8. *Comparative death rates*

Opponents say:

"Under the medical care now provided in the United States the highest level of health and the lowest death rate ever known under similar conditions are being maintained" (excerpts from American Bar Association Committee Reports on Parts of Wagner Bill (S. 1161) Relating to Federal Regulation of Medicine, reprinted in the Journal of the AMA, Mar. 11, 1944).

"The Nation's health problem is not grave, since the United States now (1943) has the lowest sickness and death rate of any large nation in the world" (hearings before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 2, p. 557, testimony of Dr. R. L. Sensenich).

The truth is:

Death rates are not a very good measure of a nation's health, and these rates are often not exactly comparable for different countries. Therefore dogmatic statements like the above are not made by scientific people.

So far as the figures go, however, they show that the United States lags behind other countries in many health records.

We have to take statistics of prewar years since figures during and since the war are either unavailable or not comparable.

In 1934–36, 18 countries had lower death rates than the United States among persons in the prime of life (age 35–64): Australia, Austria, Belguim, Canada, Denmark, England, Germany, Ireland, Italy, Luxemburg, Netherlands, New Zealand, Northern Ireland, Norway, Scotland, Sweden, Switzerland, and Wales.

Eight countries had lower death rates among children 1 to 4 years old: Austria, Denmark, Luxemburg, Netherlands, New Zeland, Norway, Sweden, and Switzerland.

Seven countries had lower infant motality rates than the United States: Australia, England and Wales, Netherlands, New Zeland, Norway, Sweden, and Switzerland (hearings before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. 4, p. 2258, memorandum from Social Security Board).

9. *Unmet medical needs*

Opponents say:

"Much has been said regarding medical neglect. In 30 years of surgical practice I have never encountered a person who suffered for lack of medical care except in a few instances where medical care was not sought or desired. There are very few places in this great country of ours where medical care is unavailable." (McCormick, E. G. (Dr.), American Democracy and American Medicine, Ohio State Medical Journal, vol. 42, No. 11, November 1946.)

The truth is:

No physician can estimate the number of people who do not come to him when they need care. To find unmet medical needs, it is necessary to interview families themselves, find out what illnesses they have had, what medical care they had—or not had—and what they paid for it. Many thousand families have thus been studied in all parts of this country.

It has been found that among low-income groups from one-fifth to one-quarter of the people obtain no medical care even in illness serious enough to disable for a week or more.

It has been found that the amount of medical service which people obtain is closely proportionate to their incomes. The amount of service may be measured in the number of visits from or to a doctor. Among low-income people ($1,000 a year or less), the average number of doctor visits per year was 2⅕. Among families with incomes of $3,000 to $4,000, the number was 3.0, while among families having $10,000 or more a year the figure rose to 5½.

Yet the amount of illness was less among the high-income people than among the poorer ones (Health Insurance, Subcommittee Rep. No. 5, 79th Cong., interim report from the Subcommittee on Health and Education, Committee on Education and Labor, U. S. Senate, on S. Res. 62, July 1946).

10. Selective Service findings

Opponents say:

"Although 40 percent of our young men examined by Selective Service are rejected because of diseases or defects, this fact is no indictment of the physicians or medical services of this country" (Lowell S. Goin, M. D., Compulsory vs. Voluntary Health Insurance, Nuea Debate Handbook, vol 1, p. 49, edited by Bower Aly, National Univeristy Extension Association, Lucas Bros., Columbia, Mo., 1946).

"* * * about two-thirds of the rejections were for causes which are beyond the powers of the medical profession to prevent or correct, regardless of the amount of medical service available and regradless of the cost of medical care" (Maurice H. Friedman, M. D., Washington, D. C., hearings before the Senate Committee on Education and Labor, on S. 545 and S. 1320, pt. 2, June 1947, p. 661).

These remarks refer especially to the large number of rejections for veneral and mental diseases, heart disease, etc.

The truth is:

It is not a question of blaming doctors or anybody else. It is a question of facing facts about existing diseases and defects.

Dr. Leonard G. Rowntree, Medical Chief of Selective Service, said:

"We are not the vigorous people that we thought we were." and * * * "There is no question but that the high cost of medical care is a factor in a very considerable proportion of those suffering from defects, illnesses, and disease * * * Conservatively, I would estimate that 700,000 of these men (4,200,000 IV–F's) are rejected for remediable defects. This means 1 out of every 6 men * * * " (Col. Leonard G. Rowntree, M. D., Chief of the Medical Division of the Selective Service System, hearings before a subcommittee of the Senate Committee on Education and Labor, on S. Res. 74, pt. 5, July 1944, pp. 1635–1639).

Venereal diseases con be greatly reduced by medical care. "The percentage of infant deathes due to syphilis has been cut one-half" during the last decade. "The spyhilis mortality rate for adults has been brought down a third. Admissions to institutions of patients suffering from syphilitic insanity have stedily declined" (Thomas Parran, M. D., Surgeon General of the United States, We Could Banish V. D. in Nine Days, Woman's Home Companion, November 1947, p. 4).

A large proportion of the cases of "nervousness," "emotional instability," and "personality disorder" which were rejected would be relieved by phychiatric treatment (Hearings before the Senate Committee on Education and Labor, on S. 1606, pt. 1, April 1946, pp. 90–91).

"On the basis of present knowledge, adequate health measures, preventive and curative, could have lowered draft rejections for * * * various cardiovascular disorders. * * *" (Charles A. R. Connor, M. D., medical director of the American Heart Association, (letter) hearings before the Senate Committee on Education and Labor, on S. 545, S. 1320, pt. 2, June 1947, p. 722.)

Hernia is easily curable by surgery. Hernia caused 260,000 rejections in 1945 (letter by Theodore Sanders, M. D., New York, to the New York Herald Tribune, Jan. 13, 1947).

The United States Public Health Service compared the records of a group of rejectees with the records of these same young men while they were in school 15 years before. A large proportion of the diseases and defects which caused rejection were found to have existed in childhood but had not been cared for (Child Health and the Selective Service Physical Standards in Public Health Report, vol. 56, No. 50, Dec. 12, 1941, pp. 3265–3275).

11. Days lost through sickness

Opponents say:

"In 1900 the average American workman lost 28 days a year from his work because of illness. In 1935, the average workman lost only 8 days of work a year from illness. Our record in illness is three and one-half times better than it was at the start of the century" (Walch, J. W., Check and Double Check, New York Medical Society of the State of New York, 1946, p. 15).

The truth is:

These statistics are phoney. The 28-day figure for 1900 is the average number of days lost by those workers who were sick. The figure for 1935 is the average number of days lost by all the workers, including those who were not sick at all as well as the ill ones.

Neither figure has changed much since 1900 (letter from William Gafafer, Chief, Statistical Section, U. S. Public Health Service, Feb. 6, 1947).

12. Britain's medical service

Opponents say:

"This is how it was in Britain. The doctor got back to his office just at 2 o'clock. 'How many?' he said to his nurse. 'Forty.' Casually, without hurrying, he put on his white jacket and poked his head into the waiting room where the 40 patients sat. 'Will those of you troubled with headache please stand,' he said. Six stood. The doctor took identical printed prescriptions out of his desk and handed one to each of the six patients and dismissed them. Then he said, 'Will those of you troubled with a cough please stand.' Another group got up, and again he handed them printed prescriptions and dismissed them. The others, he took one by one into his private office for a few minutes. Two hours later the office was empty, the 40 patients gone. This was an average of 3 minutes to a patient" (Wright, Michael, Socialized Medicine—Bad Medicine for You! Better Homes and Gardens, January 1947).

The truth is:

This statement has no basis in fact. Dr. Charles Hill, the secretary of the British Medical Association, declares it to be "gross libel." He said this in a letter to the Journal of the American Medical Association which was published in that journal on November 9, 1946. In his letter, he labeled the story a "preposterous illustration of the methods of British national health insurance practice."

He said further, "This is not the first time I have had occasion to protest against the misleading and inaccurate accounts given, evidently at second hand, by certain American doctors who are endeavoring to avert the introduction of any health insurance scheme into their own country by denouncing the British scheme" (Journal of the American Medical Association, Nov. 9, 1946).

Lancet, long-established, independent British medical publication, stated: "Both doctor and patient are pleased with their new and easier relationship. * * * Patients are also grateful to observe that the new service is truly comprehensive. * * * Complaints are few" (Lancet, Nov. 20, 1948, 2:823).

TWENTY QUESTIONS ON THE HEALTH OF THE UNITED STATES AND THE NEED FOR NATIONAL HEALTH INSURANCE

I. HOW OFTEN ARE PEOPLE ILL?

1. Among 1,000 average people during a normal year (*1*): 1 out of 3 will be sick once; 1 out of 7 will be sick twice; 1 out of 20 will be sick 3 or more times. In addition, there is unrecognized illness among many persons who consider themselves healthy.

2. At least 8,000,000 people—1 out of 18—are incapacitated by sickness or injury in any 24-hour period. About one-half of these will remain disabled for 6 months or more (*2*).

II. HOW OFTEN DOES PREMATURE DEATH STRIKE?

In terms of people: 1,395,617 Americans died in 1946 (*3*); 1 out of every 2 was under 65 (*3*); 5,153 mothers died in childbirth in 1946 (*3*); 111,063 infants died before reaching their first birthday in 1946 (*3*).

III. HOW MUCH DO MATERNITY AND INFANT DEATH RATES VARY AMONG THE STATES?

Widely: The death rate among women at childbirth is nearly three times as high in the five highest States as compared with the five lowest. In Connecticut, Minnesota, Nebraska, Oregon, and South Dakota, 9 to 10 mothers died per 10,000 live births (1946).

Compare this rate with 26 to 31 mothers dying in Alabama, Florida, Georgia, Mississippi, and South Carolina for the same year (*4*).

Infant mortality rates tell the same story. In the five lowest States (Arkansas, Connecticut, New Jersey, Oregon, and Utah), 27 to 29 babies died per 1,000 live births (1946).

In the five highest States (Arizona, Maine, New Mexico, South Carolina, and Texas), 41 to 78 infants died in their first year (*5*).

IV. WHAT DO SICKNESS AND DISABILITY COST ANNUALLY?

1. In terms of people: 25,000,000 people suffer from chronic disease or physical impairment (*6*); about 3,000,000 workers became incapacitated in this way during 1947 (*6*); over 40 percent of the Nation's selectees examined were unfit for military service; many had remediable or preventable diseases or defects (*2*).

2. In terms of production: More than 1½ billion man-days are lost annually (*6*). The average industrial worker is off his job about 6 days annually due to short-term illness, which includes all absences because of sickness or injury that last from 1 day to 6 months; and there are nearly 3,000,000 potential workers annually prevented from working by total disability (*6*).

3. In terms of money: $27,000,000,000 annually is the total cost of sickness and disability, including direct wage losses, direct business costs, plus "hidden costs" of loss of future earnings because of disability. Medical costs amount to about $8,000,000,000 more (*6*).

V. HOW MANY DOCTORS DO WE HAVE?

1. The number of active physicians in private practice was estimated to be 144,572 as of February 15, 1948, including an estimated 45,000 who limit their practice to a specialty (appendix I).

(*a*) This was about 1 active physician in private practice for every 1,000 potential patients.

(*b*) If we leave out specialists, there was about 1 active physician in private practice for every 1,500 people in the United States.

2. There are 167,459 active non-Federal Government physicians in the United States today, including an estimated 45,000 who limit their practice to a specialty. Of the remainder, 99,572 are estimated to be general practitioners, 18,487 are hospital interns and residents, 4,400 are employed by insurance companies, industrial firms, etc. (appendix I).

(*a*) This means there was about 1 active non-Federal Government doctor to every 884 potential patients (*7*). This average includes specialists and all types of doctors, but excludes a total of 18,591 Army, Navy, Veterans' Administration and Public Health Service doctors (appendix I).

3. 667 potential patients per physician is a recognized standard (*6*). This average includes all doctors except those in Federal Government service.

(*a*) This mean 54,430 more active non-Federal Government physicians are needed to meet the accepted standard, an increase of 30 percent over the number now available (*8*).

VI. HOW ARE DOCTORS DISTRIBUTED AMONG THE STATES?

1. Doctors are not distributed evenly. In the three States with the most favorable ratio and the District of Columbia in 1940 (Colorado, Massachusetts, and New York), there was 1 active doctor per 437 to 636 persons.

2. But there was only 1 active doctor per 1,502 to 1,606 persons in the 4 States with the least favorable ratio (Alabama, Mississippi, New Mexico, and South Carolina) (*9*).

VII. HOW ARE DOCTORS DISTRIBUTED WITHIN THE STATES?

There also exist differences in the distribution of active physicians within the States. The cities have more than their share; the rural areas less. In 1946, for example, 330 counties (10 percent of the total of 3,070 counties) had less that 1 active physician per 3,000 population; 75 counties had no active doctor (*10*).

VIII. HOW MUCH DO DOCTORS EARN?

1. The average net income of doctors in independent practice in 1947 was $11,300. In communities under 5,000 population and in communities of 1,000,000 and over, the average was about the same, $9,450. Average net income was highest in communities between 500,000 and a million—$13,100 (*11*).

2. Average gross income, without deductions for expenses, was $18,500 in 1947. However, 1 doctor in 10 had a gross income below $7,500; 2 in 10 a gross income below $9,500. All of these figures include general practitioners, partial and complete specialists (*11*).

IX. DO WE HAVE ENOUGH HOSPITALS?

1. There were 6,276 hospitals in the United States in 1947. Their capacity was 1,425,222 beds (*12*). Four and one-half beds per 1,000 population is a minimum standard (excluding mental and tuberculosis beds). Judged by this standard (*13*):

(*a*) Four counties out of every ten have no acceptable general hospital. Fifteen million Americans live in these counties with no approved general hospital.

(*b*) Only 14 percent meet the standard.

X. WHAT HOSPITALIZATION DO PEOPLE GET?

An average of one in nine persons in the United States was admitted to a registered hospital in 1947. Of these 15,829,514 patients (*12*):

1. 15,438,480 or 97.5 percent went to general and special hospitals.[1]
2. 291,954 or 1.9 percent went to nervous and mental hospitals.
3. 99,080 or 0.6 percent went to tuberculosis hospitals.

XI. HOW MANY NURSES ARE THERE?

There were 173,055 active registered professional nurses in 1941—an average of 1 per 760 people. The highest State (Vermont) had 1 nurse per 336 people. The lowest State (Mississippi) had 1 nurse per 2,143 people (*14*).

XII. IS THERE A SHORTAGE OF NURSES?

Yes. The National Nursing Council's Committee on Statistical Research says we were short 41,000 nurses as of August 1946 (*15*). Further, there were only 30,899 student nurses who began training that year, compared with 56,567 in 1945 (*15*).

XIII. DO WE HAVE ENOUGH FULL-TIME PUBLIC HEALTH SERVICES?

1. No; 40,000,000 Americans live in more than one-third of our counties which have no full-time public health department (*16*).

2. In order to supply bedside nursing, 1 public health nurse per 2,000 persons would be necessary (*6*). The 1948 national average was only 1 public health nurse per 6,500 persons. There were only 22,605 public-health nurses in 1948 (*17*).

XIV. WHAT DO WE SPEND ON HEALTH COMPARED WITH OTHER THINGS?

Item	Amount	Percentage of—	
		National income, 1947	Disposable personal income, 1947
Medical care (including insurance and supplies)	$6, 507, 000, 000	3. 2	3. 7
Alcoholic beverages	9, 640, 000, 000	4. 8	5. 6 (18)

It must be remembered that medical care is neither a desired comfort, nor a desired necessity like food. It is an undesired necessity.

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[1] Includes maternity, industrial, eye, ear, nose, and throat, children's, orthopedic, isolation hospitals, convalescent and rest homes, etc.

XV. HOW MUCH DO WE SPEND ON MEDICAL RESEARCH?

1. The Federal Government spends about $28,000,000 a year for research and development in medical and allied sciences (*19*).

2. By contrast, the expenditure for research in plant and animal diseases was almost $30,000,000 for 1 Federal agency alone (1947) (*20*).

3. Business spends about $450,000,000 a year on industrial research (*21*).

XVI. WHY DO AMERICANS NEED HEALTH INSURANCE?

1. Every American may be hit any year by sickness, costs ranging from a few dollars to hundreds or thousands of dollars. No one can predict in advance whether his sickness bills next year will be unimportant or crushing. Therefore, everybody (except the wealthy) needs health insurance.

2. The people who have no incomes and must be supported by public or private charity, must, of course, have their sickness bils paid for them. But Americans do not want to turn to charity as a way of meeting their sickness bills.

XVII. HOW MANY AMERICANS CANNOT MEET SERIOUS SICKNESS COST WITHOUT ASSISTANCE?

1. Not just the poor, but the vast majority—nearly 80 percent—of all families. (*6*), about 117,824,000 persons. These are the people who cannot meet serious sickness costs, or can meet them only by exhausting savings, going into debt or seeking charity.

2. In 1939, it was estimated by the American Medical Association that families with incomes under $3,000 needed help to meet the costs of serious illnesses (*22*).

3. Considering the increased cost of living, a family must have about $5,000 now to sustain a 1939 $3,000-income standard of living (*23*).

4. Nearly 80 percent of all American families had incomes of less than $5,000 in 1947 (*24*).

5. At the National Health Assembly held in Washington at the beginning of May 1948, the representatives of 17 national organizations agreed that: "The principle of contributory health insurance should be the basic method of financing medical care for the large majority of the American people, in order to remove the burden of unpredictable sickness costs, abolish the economic barrier to adequate medical services, and avoid the indignities of a 'means test'."

XVIII. HOW MANY PEOPLE ARE COVERED BY VOLUNTARY HEALTH INSURANCE PLANS?

About 27,000,000 persons have hospitalization insurance combined with physicians' services in hospitals, and approximately another 27,000,000 persons are covered for hospitalization insurance alone. Only about 3,500 persons are covered for anything approximating comprehensive care, including home and office care from physicians, as well as hospitalization and physicians' care in the hospital (*25*).

XIX. HOW WOULD NATIONAL HEALTH INSURANCE COMPARE WITH OUR PRESENT SYSTEM OF PAYING FOR MEDICAL CARE?

1. In 1947, over 6.5 billion dollars were spent by the people of the United States for medical care, including medical and hospital services, medicines and supplies, and health and accident insurance. In 1941 the total amount spent on medical care was over 3.4 billion dollars (*26*).

2. The amount spent for medical care by families varies with the various income levels. For example, in 1941, the average family with a yearly income of $1,250 spent $43 for those items of medical care included under a national health insurance plan. For an income of $2,500 the comparable average expenditure was $74; for an income of $3,600, it was $143 (*27*).

3. The annual contribution proposed under national health insurance would be 3 percent of earnings, but in the case of employed persons half of this would be paid by the employer. Thus:

An employee earning $1,250 yearly would contribute $18.75.
An employee earning $2,500 yearly would contribute $37.50.
An employee earning $3,600 yearly would contribute $54.

If there is more than one earner in the family, the total contributions would be higher than those listed above, because each earner would be contributing. However, even when this is taken into consideration, the payments required of employed persons under national health insurance would be much less than these people spend at present for medical care (*27*).

XX. DO AMERICANS WANT NATIONAL HEALTH INSURANCE?

1. A Nation-wide poll by the National Opinion Research Center in 1944 showed 82 percent thought something should be done to help people pay for medical care; 85 percent thought social security should include doctor and hospital care; 58 percent were willing to pay a 2½-percent deduction for this care (*28*).

2. Public-opinion polls in several States show: 84 percent of New York State residents want health insurance (poll by New York State Commission on Medical Care, 1946) (*28*); 70 percent of Washington, D. C., residents endorse national health insurance (poll by Washington Post, 1946) (*28*); 50 percent of California residents favored some Government medical plan (poll by the California Medical Association, 1946) (*29*).

Reference list

(1) I. S. Falk, C. Rufus Rorem, and Martha D. Ring, "The Costs of Medical Care," Publication No. 27, Committee on the Costs of Medical Care, University of Chicago Press. 1933.
(2) Senate Subcommittee Report No. 5, Seventy-ninth Congress (Health Insurance), July 1946, page 1; total figure on number incapacitated (item I) increased from 7 to 8 million to adjust for population and other changes for the lapse of time between the date to which the original source applied and 1948–49.
(3) United States Public Health Service, National Office of Vital Statistics, Special Reports, volume 28, No. 1, September 13, 1948.
(4) Ibid. Volume 29, No. 7, November 17, 1948.
(5) Ibid. Volume 29, No. 8, November 22, 1948.
(6) "The Nation's Health," by Oscar R. Ewing, Federal Security Administrator. A report to the President, September 1948.
(7) 148,000,000 (estimated 1948 population) divided by 167,459 equals 1 active non-Federal Government doctors to every 884 potential patients.
(8) Appendix I: 167,459 active non-Federal Government doctors available. 148,000,000 (estimated 1948 population) divided by 67 equals 221,889 non-Federal Government doctors needed, or an increase of 30.7 percent.
(9) National Health Assembly Personnel Section—Material supplied by United States Public Health Service.
(10) Survey of Location of Physicians in the United States, Bureau of Information, American Medical Association, 1947.
(11) Medical Economics, October 1948, page 71; November 1948, page 61.
(12) Journal of the American Medical Association, August 14, 1948 (hospital number).
(13) Senate Committee Print No. 3 (Hospital Survey and Construction Bill), Seventy-ninth Congress, March 1946, page 52.
(14) Senate Committee Print No. 5 (Medical Care Insurance), Seventy-ninth Congress, July 1946, pages 109–110.
(15) Journal of the American Medical Association, January 11, 1947, page 110.
(16) President Truman's message to Congress, November 19, 1946.
(17) Federal Security Agency, Public Health Service. Total Number of Nurses Employed for Public Health Work in the United States. 1948.
(18) Department of Commerce, letter, dated March 25, 1949.
(19) Report of the President's Scientific Research Board, "The Nation's Medical Research," volume V, October 18, 1947, page 15.
(20) Budget of the United States, fiscal year ending June 30, 1948.
(21) Report of the President's Scientific Research Board, volume I, August 27, 1947, page 12.
(22) Families with incomes under $3,000 need help to meet the cost of serious illness. ("Factual Data on Medical Economics," pamphlet issued in 1939 by the Bureau of Medical Economics of the American Medical Association.)
(23) Consumer Price Index No. 171.7, June 15, 1948. Bureau of Labor Statistics, Department of Labor, Washington, D. C.
(24) The Economic Report of the President, January 1949, page 93.
(25) Report compiled by Katherine G. Clark of the staff of the Committee on Research in Medical Economics, under the direction of Michael M. Davis, chairman. March 1949.
(26) "The Cost and Quantity of Medical Care in the United States", by Frank G. Dickinson, research director, American Medical Association. Bulletin 66, September 1948.

(27) Senate Committee Print No. 5, Seventy-ninth Congress, July 8, 1946, page 158.
(28) Senate Committee Hearings on National Health Program, Seventy-ninth Congress, part I, April 1946, pages 66–72.
(29) Medical Economics, July 1944, page 53.

APPENDIX I

Estimated number of physicians in general practice [1]

Total number of physicians in the United States in 1942 directory			180, 496
New names added		37, 370	
Deaths deleted	19, 263		
Cut from directory	357		
Total deletions		19, 620	
Net gain (Feb. 15, 1948)			17, 750
Total number of physicians in the United States as of Feb. 15, 1948			198, 246
Retired or not in practice		8, 300	
Not in private practice (employed by insurance companies, industrial firms, etc.)		4, 400	
Full-time hospital service:			
Interns	7, 685		
Residents and fellows	10, 802		
Superintendents of hospitals (MD's)	2, 654		
Full-time MD's in TB, nervous, and mental hospitals	1, 242		
Full-time hospital service, total		22, 383	
Government service:			
Regular Army	1, 175		
Regular Navy	1, 901		
U. S. Public Health Service	1, 129		
Marine Corps, Army of the United States, and United States Naval Reserve	7, 033		
Under investigation (reported relieved of duty)	1, 853		
Veterans' Administration	5, 500		
Government service, total		18, 591	
Total number of physicians not in private practice (including military personnel as of Feb. 15, 1948			53, 674
Net estimated number of physicians in United States in private practice			144, 572
Estimated number of physicians limiting practice to a specialty			45, 000
Estimated number of physicians in general practice			99, 572

[1] This table obtained on Mar. 12, 1948, from Directory Department, American Medical Association, 535 North Dearborn St., Chicago, Ill.

(Senator Smith submitted the following material for inclusion in the record:)

UNITED STATES SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
July 25, 1949.

Hon. JAMES E. MURRAY,
Chairman, Subcommittee on Labor and Public Welfare,
United States Senate, Washington, D. C.

MY DEAR SENATOR MURRAY: I am transmitting to you herewith a group of communications which I have received since January of this year from the governors of 31 States, setting forth their views and preferences on the alternative proposals for Federal medical-care legislation. Because of the importance of their positions in our American governmental structure, and of the interest which their considered views should command, I request that these expressions from our State governors be printed in full in the record of the present hearings, along with an explanatory preface prepared in my office.

Let me take this opportunity to express my regret that illness prevented me from taking part in the recent hearings before the Health Subcommittee. I have followed the record of the hearings with much interest, and I believe that the enclosed material from the governors will make a valuable addition to it.

Always cordially yours,

H. ALEXANDER SMITH.

VIEWS OF STATE GOVERNORS ON FEDERAL HEALTH LEGISLATION

I. ANALYSIS OF GOVERNORS' REPLIES TO 1947 AND 1949 INQUIRIES

In August 1947 letters were sent by Senator H. Alexander Smith, chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare in the Eightieth Congress, to the governors of each of the States, requesting that they express their views and preferences on the two major health bills then pending before the subcommittee. These bills were S. 1320, providing for a system of national compulsory health insurance, and S. 545, providing for Federal grants-in-aid to help the States establish their own programs for making medical and dental services available to people of low income. Senator Smith pointed out in his letter to the governors that his inquiry was prompted by a desire to further "a larger participation by the States in the formulation of important national policies."

Of 38 governors replying at that time, either directly or through their State health officers, 26 indicated a preference for the approach represented by S. 545, and none favored S. 1320. The remainder either opposed both bills or indicated no preference.[1]

Views of the State governors on national health legislation, 1947 and 1949

[A indicates 1947 view; B indicates 1949 view]

	On compulsory health insurance			On grant-in-aid proposal			Wants State action only	No preference indicated	No report received
	Favors outright	Prefers	Opposes outright	Favors outright	Prefers	Opposes outright			
Alabama		B			A				
Arizona								A	B
Arkansas			B		B				A
California			B		B				A
Colorado								B	A
Connecticut					A				B
Delaware			B	B	A B				
Florida								A	B
Georgia								A	B
Idaho			B		A B				
Illinois					A				B
Indiana			A		A B		B		
Iowa			A	A	A				B
Kansas			B		B				A
Kentucky			A	A	A			B	
Louisiana			B		B			A	
Maine			A		A B				
Maryland			B		B				A
Massachusetts			A B	A	A			B	
Michigan	B	B	A	A	A	B			
Minnesota			B	B	B				A
Mississippi			A		A				B
Missouri	B	B	A		A	B			
Montana			A		A				B
Nebraska			A B		A B				
Nevada									A B
New Hampshire			A B		A	B	A	B	
New Jersey			A			A	A	A	B
New Mexico								A B	
New York			A B		B			A	
North Carolina					B				A
North Dakota			A	A	A				B
Ohio			A		A		A		B
Oklahoma									A B
Oregon			B		A			B	
Pennsylvania			A B	A B	A B				
Rhode Island								A	B
South Carolina			B	B	B			A	
South Dakota			A B	B	A B		A		
Tennessee			A			A		A	B
Texas									A B

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[1] The 1947 correspondence appears in "Hearings * * * Before a Subcommittee of the Committee on Labor and Public Welfare, United States Senate, 80th Cong., * * * on S. 545 * * * and S. 1320 * * *," pt. 4, pp. 1835–1883.

Views of the State governors on national health legislation, 1947 and 1949—Contd.

[A indicates 1947 view; B indicates 1949 view]

	On compulsory health insurance			On grant-in-aid proposal			Wants State action only	No preference indicated	No report received
	Favors outright	Prefers	Opposes outright	Favors outright	Prefers	Opposes outright			
Utah			A B			B		A B	
Vermont			A B	A B	A B				
Virginia			A B		A	A B	A B	B	
Washington			B			B	B	A B	
West Virginia			A	A	A				B
Wisconsin			A B		A	B	B	B	
Wyoming			A B	A	A	B		B	
Total 1947	0	0	24	9	26	3	5	12	10
Total 1949	2	3	22	6	17	8	4	11	17
Percent of those reporting:									
1947	0	0	63	24	68	8	13	32	
1949	6	10	71	19	55	26	13	35	

The present correspondence is of a similar nature. It was felt that changes since 1947 in the governorships of a number of States, increased activity and public discussion bearing on Federal health legislation, and the expectation of similar legislation in the Eighty-first Congress, warranted seeking new opinions in order to determine whether any major change had occurred in the views of the governors. Senator Smith therefore renewed his correspondence with the governors in January 1949, stating the alternatives in much the same form and asking for comments.[2]

As this is written, 31 governors have replied with comments on the alternative approaches to Federal medical-care legislation. Most of those who have not sent full replies stated that they desired to do so but had been detained by the demands of legislative work in their own States.

The texts of the replies from governors or their State health officers are printed following this introduction. In addition there is attached in tabular form an analysis of the replies received as compared with those received in 1947. This break-down shows, in somewhat more depth than a yes-and-no analysis would permit, the positions which the governors took in both years on the alternative proposals, and on the general question of the proper role of the States in dealing with national medical care problems.[3]

Three out of thirty-one governors reporting in 1949, as compared with none out of thirty-eight in 1947, showed a preference for the alternative of national compulsory health insurance, and two of these indicated outright support for the measure. This change, however, was counterbalanced by a noticeable rise in the percentage of those who indicated outright opposition to compulsory health insurance, from 63 percent (24 out of 38) in 1947 to 71 percent (22 out of 31) in 1949. It is probably safe to say that in 1949 more governors had definite views on compulsory health insurance than in 1947.

The same is not true of the governors' views on alternative possibilities. While in 1947 the letters showing preference for the grants-in-aid approach numbered 26, this figure in 1949 fell to 17—a drop from 69 to 55 percent in terms of the total number of governors reporting in the two surveys. A similar decline (from 24 percent down to 19 percent appears in the group whose attitude toward grants-in-aid went beyond mere preference to the point of outright support.

These decreases in preference for the grants-in-aid proposal were accompanied by a rise in the number of governors showing outright opposition to it. Not counting those favoring national compulsory health insurance, the number of opponents of grants-in-aid rose from three (or 8 percent) in 1947 to six (or

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[2] The text of Senator Smith's letter is reproduced following this introduction.

[3] The letters vary in scope, explicitness, and approach, and are consequently difficult to classify with precision. The categories used in this table were chosen to permit valid and significant conclusions without doing violence to this variety. In the analysis a State was recorded as taking one or more of the positions shown in the table if these positions were either specifically expressed or clearly implied in the letter. This procedure necessarily involves subjective judgments, but the diverse nature of the material made more precise methods impossible.

19 percent) in 1949. Meanwhile the number of those who held that medical-care legislation should be the exclusive province of the States was five in 1947 and four in 1949—a constant proportion of 13 percent.

Finally, it is worth noting that the governors who indicate no preference between the two proposals still constitute an important group. Eleven governors were so classified in both years—a slight proportionate rise from 32 to 35 percent.

Conclusions: Despite the incompleteness of the response in both years, these general conclusions on gubernatorial opinion can be drawn from the two surveys:

1. The majority of governors still show a clear preference for the grants-in-aid proposal, though this majority has declined, and the percentage indicating outright support of the grants-in-aid plan (as distinguished from preference) has also declined slightly.
2. A small minority (under 10 percent) of those reporting now prefer compulsory health insurance on a Nation-wide basis.
3. A significant and perhaps growing minority decline to state any preference between the alternatives as presented. An increasing number within this group appear to have refrained on the ground either that they wanted no outside aid of any kind or that they distinctly opposed both the alternatives suggested. At all events these "neutrals" have in both years seemed desirous of finding better alternatives than any yet offered, or at least of gathering more evidence before making a choice.

A reading of the letters will further show that considerable interest exists among governors in a variety of possible solutions on the local and State levels (including, in the cases of California and Massachusetts, the use of the compulsory-health-insurance principle on a State-wide instead of a Nation-wide basis). This tendency to approach the problem on the State and local levels is matched by a general reticence, and awareness of complexity, in considering Federal legislation which will supplement and not conflict with existing or contemplated State and local activity. These factors would appear to account largely for the size of the noncommittal group and for the negative attitudes of a number of governors on both proposals.

II. TEXT OF SENATOR SMITH'S LETTER TO THE GOVERNORS, JANUARY 1949

MY DEAR GOVERNOR: As a member of the Committee on Labor and Public Welfare of the United States Senate, I am writing to you. Our committee will soon have the responsibility of considering legislation having to do with the over-all health situation in the United States. During the Eightieth Congress, which was Republican controlled, I was chairman of the subcommittee on Health of the Labor and Welfare Committee. During this Congress, which is Democratic controlled, of course there will be a Democratic chairman of the subcommittee.

Our national health problems, and the respective roles which the States and the Federal Government ought to play in efforts to solve them, are again a focus of congressional attention in the Eighty-first Congress. For the information of us all, and especially for my own benefit in dealing with these problems on the committee, I want to present the situation to you as the Governor of your State and to ask for your judgment on it. In August 1947, I wrote similar letters to all our governors. The replies furnished valuable information to our subcommittee and were inserted in the record of the hearings then in progress. I am writing at this time not only because we have a number of new governors, but also because recent developments may have affected the situation in various States and the opinions of their chief executives.

The vexing problem which still faces us is that of making good medical and hospital services available to all the people, regardless of their individual ability to pay. It is generally agreed that these services ought to be available, and that to provide them fully more facilities and professional personnel are needed. But there is no such agreement as to how increased services ought to be paid for, nor as to the proper roles of the various levels of government.

It was on this issue that the Senate committee divided sharply during its deliberations last year. The opposing solutions, represented by two bills, were essentially as follows:

1. A Nation-wide health-insurance system, to be financed by a uniform percentage tax on all individual wages or income up to $3,600 a year per person, with pay-roll taxes matched by employer contributions. This tax would furnish the bulk of a national health insurance fund, out of which the Federal Government would finance through the States (or, in a noncomplying State, through its own agents) comprehensive medical, hospital, and other health care for the whole

population. Complying States would administer their own allotments from the national fund and would contract with practitioners, hospitals, etc., for the provisions of services, under Federal rules and regulations. Within limits set by the Federal agency, all individuals would be entitled to comprehensive care.

2. A 5-year program of Federal grants-in-aid to the States. Each State would be invited to survey its health needs and resources, and to develop its own plan for the broadest possible distribution of high-quality medical and hospital services regardless of the individual's ability to pay. The State would retain broad discretion as to its methods of carrying out that purpose. The cost of approved State plans would be shared on a matching basis between the State and the Federal Government. I feel it would be entirely appropriate for any individual State, as distinguished from the Federal Government as a whole, to adopt a compulsory health insurance program to cover all the people within its jurisdiction.

Both of these approaches are sure to be represented by new bills before our Senate committee in 1949. The views of our 48 State governors, in my opinion, should be given great weight in the resulting deliberations. Therefore, I am asking you to express any preference you may have as between the general alternatives outlined above, together with any other comments you may wish to make. Your cooperation will be of great benefit to us in our efforts to form a sound national policy on this vital question.

I may add that, in the course of the Senate hearings held during the last Congress, the statement was made that the issue was entirely a Federal matter in which the States were in no way concerned. For my part I completely disagree with that thought, and firmly believe that no major national health legislation should be reported out until our State governors have had a full opportunity to make known their views.

Always cordially yours,

H. ALEXANDER SMITH.

III. TEXTS OF THE GOVERNORS' REPLIES, 1949

STATE OF ALABAMA,
EXECUTIVE DEPARTMENT,
Montgomery, February 9, 1949.

Senator H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: Your request for an opinion concerning the type of national health legislation preferred has been received. Thank you so much for your inquiry.

We are in complete agreement with you that means must be found which will make adequate medical care and hospital services available to all citizens, regardless of individual ability to pay.

It would seem that under alternate plan 1 (described in your letter) a more satisfactory distribution of health care could be effected. This plan would insure the income to the individual State on the basis of need, whereas the income under alternate plan 2 (as outlined in your letter) would be dependent upon ability of the State to match grants-in-aid. It would also seem entirely possible for the program to be administered according to local needs and in keeping with Federal regulations without undesired interference with the rights of individual States.

Sincerely yours,

JAMES E. FOLSOM, *Governor of Alabama.*

STATE OF ARKANSAS,
OFFICE OF THE GOVERNOR,
Little Rock, May 20, 1949.

Hon. H. ALEXANDER SMITH,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: Your letter dated May 10, 1949, and enclosed copies of Senate bills S. 1679, S. 1456, and S. 1581 are appreciated. This office as well as the citizens of this State are, of course, vitally interested in improving and providing adequate medical service for our people.

I sincerely feel that each of these proposed legislative measures has some definite merit. However, I also feel that some very undesirable provisions are proposed which are not in keeping with our democratic American traditions.

I feel definitely that compulsory health insurance as outlined in present legislation is not desired by the majority of the American public. I feel that a voluntary health insurance plan should be developed which is fair and equitable to the population of the country and also fair and equitable to our medical profession. I also feel that the country as a whole is urgently in need of additional qualified physicians and that the grade A medical schools of this country should be urged and induced to increase enrollment but this increased enrollment should not be necessarily effected through the direct subsidy by the Federal Government to institutions of medical education as is now being proposed. This same thinking should also be applied to schools of nursing since we are also in need of the services of many more well trained nurses.

Senate bill 1581 most certainly has its good points with reference to the creation of a national health agency and also provides funds on a matching basis to States for medical and hospital service planning, the development of voluntary health insurance plans, hospital construction, expanded local public health services, and other provisions. However, it also provides for certain school health services for school children through Federal subsidy to the extent of complete medical care which we do not feel could be justified since we cannot justify the compulsory health insurance plan as a whole.

Without question, local health services throughout the country should be expanded in proportions that will provide at least minimal adequate health services to 90 percent of our population. This, of course, must be done through the financial participation of local units of government, private organizations, State governments, and the Federal Government.

It is also my feeling that adequate medical services should be provided for the citizens of this country but such services should be provided on strictly a voluntary basis and the ability of the individual or family to financially participate in such a plan.

It is my understanding that shortly after June 1, 1949, the medical profession of the country, through the American Medical Association, will draw up and submit to Congress an over-all bill or proposal to include voluntary health insurance, school health service, hospital construction, increased enrollment in medical schools and schools of nursing, and also provide for adequate public-health services for the Nation.

It is my sincere wish that some satisfactory compromise can be reached between the proposed legislation that will be submitted by the medical profession and the pending legislation dealing with the same subjects now before Congress which will provide adequate medical care and public-health services for the citizens of our country.

Sincerely yours,

SID MCMATH.

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento 14, February 2, 1949.

HON. H. ALEXANDER SMITH,
Member of the United States Senate,
Senate Office Building, Washington, D. C.

MY DEAR SENATOR: Your letter of January 24 addressed to Governor Warren has ben received during his absence from Sacramento. It will, I assure you, be called to his attention promptly.

With reference to your request for information relating to the over-all health situation in California, we have in our files three surveys and reports to the Governor and to the 1949 session of the California Legislature. They are as follows:

1. Chronic-disease program for California.
2. The problem of the severely handicapped spastic and crippled children and adults.
3. A report on rheumatic fever.

Since it may be helpful for you to have at once the Governor's most recent recommendation to the legislature on public health, I quote from his annual message delivered to the legislature on January 3, 1949:

"No State can absorb millions of new residents as swifty as California without being confronted with conditions calling for vigorous steps to protect the public health. We have made considerable progress in the last few years through measures designed to reorganize and improve our State department of public health, to raise the standards of local health departments and assist them financially, to stimulate the construction of new community hospitals, to speed up the fight against tuberculosis and cancer, to expand the medical center at San Francisco, and to establish a new and badly needed medical center at Los Angeles.

"We have not, however, come to grips with the fundamental problem of bringing good medical care within the financial means of the average family. We have developed high standards of medical service and facilities in our States, but they have become so costly as to be beyond the means of a large percentage of our people.

"I do not refer to those who are indigent. The public hospitals and clinics in most places supply them with adequate services. I refer to those who work hard for modest pay and who do not want to become indigent, who want to raise good American families and pay their own way as they go through life. They are the backbone of America.

"For these people—and there are millions of them in California—the cost of medical care is so high that they cannot pay for it without crippling their finances and without depriving themselves of other things that are needed to raise a good American family.

"I believe this situation can be remedied by a system of health insurance to which everyone contributes and through which everyone will receive benefits in time of sickness.

"In 1945 and 1947 I recommended such a system, but the bills were never permitted to reach the floor for debate—this in face of the fact that it was recommended by a special interim committee of the senate in January 1947.

"I also repeat that this should be and can be done without interfering with the traditional freedom of choice between patient, hospital, and doctor—a freedom which I have always wanted to see preserved—and that it can be done without socialization of either our physicians or our hospitals—a system to which I have always been opposed."

Under separate cover, I am sending a copy of senate bill 157 which was introduced pursuant to this recommendation, a copy of the pamphlets on health insurance which were written in behalf of the Governor's recommendations in 1945 and 1947, and copies of the Governor's annual message to the legislature and budget message for 1949, with relevant portions marked.

We shall obtain from the director of the department of public health a report giving the general information on health services in California.

I know the Governor will answer your letter personally as soon as possible.

Sincerely,

HELEN R. MACGREGOR,
Private Secretary.

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento, February 15, 1949.

HON. H. ALEXANDER SMITH,
Member of the United States Senate,
Senate Office Building, Washington, D. C.

MY DEAR SENATOR: The request contained in your letter of January 24 for my views on public-health laws in general, and health insurance in particular, is greatly appreciated.

My secretary has previously sent you copies of certain reports on specific health problems in California. She has also sent you a copy of the health-insurance bill which I am sponsoring in this session of our legislature, and of pamphlets which have been used during earlier sessions. These, together with the marked excerpts from my message to the legislature, accurately set forth my views on this important subject.

In your letter you suggest two viewpoints which you find to be prevalent as to the possibilities for Nation-wide health insurance. The first, a Nation-wide health-insurance system with a Federal fund out of which the Government would finance through the States comprehensive medical, hospital, and other health care for the whole population. The second would be a program of Federal grants-in-aid to encourage the adoption of State plans with Federal participation.

Since I am firmly of the opinion that as many functions as possible should be administered by agencies as close to the people as possible, it is my view that State health-insurance systems would be preferable to a national system. This is one of the reasons why I have urged the adoption of a plan for equitably distributing the cost of medical care in California. I am convinced, however, that the time for the States to adopt such a system is very short. If they do not seize their opportunity a Nation-wide system is inevitable. I hope that our various States will realize this before it is too late and that they will adopt adequate State plans for insuring adequate distribution of medical care to all their people.

Sincerely,

EARL WARREN, *Governor.*

STATE OF CALIFORNIA,
GOVERNOR'S OFFICE,
Sacramento, February 18, 1949.

HON. H. ALEXANDER SMITH,
Member of the United States Senate,
Senate Office Building, Washington, D. C.

MY DEAR SENATOR SMITH: This is with further reference to your letter of January 24 to Governor Warren inquiring about health conditions in California.

He has now received the report from our director of public health giving a general survey of health conditions, and I quote from it:

"General health problems in California are probably not as acute as they are in many other States of the Union. There are factors, however, which require special attention and effort.

"Of the 58 counties in California, 38 are served by organized county health departments. All of the cities in 26 of these counties are served by the county health department. Of the 303 incorporated cities in California, 226 are served by organized county health departments, 13 operate their own full-time city health departments, and 64 receive no organized services whatsoever. The 20 counties which are not served by organized health departments embrace approximately 35 percent of the State's area, but include only 5 percent of the State's population.

"Since the inception of the program of State financial aid for local health departments, there have been established seven new county health departments, and two new city health departments. A number of other cities have placed themselves under the jurisdiction of the county health department. Del Norte County has combined with Humboldt County into a bi-county health unit, the second of this type in this State. Throughout the State there has been marked increase in the general level of service provided, and in a number of instances new services have been added as a result of stimulation of these State assistance funds.

"There is still room for improvement of the services provided by organized health departments to the 95 percent of the State's population under their jurisdiction. An outstanding need is the provision of adequate public-health centers, both for use as housing of the central headquarters of the department and as auxiliary facilities located in strategic areas within each jurisdiction.

"For the 5 percent of the State's population not served by organized local health departments, programs must be developed which specifically meet special local situations, instead of conforming to a preconceived plan based on a general or average situation. It, therefore, is not necessary in some areas that local health programs include the same services that are provided in more densely populated areas. Emphasis must be placed on the control of the environment, on public-health nursing, and on the utilization of the practicing physician and his office as a source of preventive medical services.

"If organized programs are developed in these areas, the higher cost of services due to low density of population, the general topography of the area, the necessity of paying higher salaries to attract and retain personnel, must be taken into consideration. Increased financial aid from State and Federal Governments will stimulate the provision of services, but such aid must not interfere with local responsibility or authority for providing public-health services.

"As programs are developed, health centers must be provided. Utilization of funds made available through the Hill-Burton Act and California's Hospital Construction Act will assist in the provision of this housing, both in the rural areas and in the more heavily populated areas.

"As a result of California's population increase and the lag in the replacement of hospital facilities and in the provision of new hospital facilities, there is a great shortage of hospital beds. The California hospital survey has indicated the following need for hospital beds, based upon standards established by the United States Public Health Service:

	Estimated need	Available acceptable	Shortage (including replacements)
General and allied special	42,039	20,568	21,471
Mental	46,710	28,310	18,400
Tuberculosis	9,598	2,231	7,367
Chronic	18,684	3,434	15,250
Total	117,031	54,543	[1] 62,488

[1] Included in the 62,488 bed shortage are 17,939 beds which either should be replaced or will require alterations in order to be classified as "acceptable."

"The Hospital Advisory Council in the very near future will consider the utilization of hospital construction funds for construction of beds for the care of the tuberculous and for the chronically ill and for the construction of public health centers, as well as general and allied specialty hospital beds.

"During the past year State and Federal aid has been approved for the construction of 19 hospitals, providing 618 beds for the acutely ill. These are located in the rural areas of the State. It is obvious that this has met only a small fraction of the total needs of the State.

"As the chronic disease program of this department and the rheumatic fever survey continue, the need for immediate provision of chronic beds will be emphasized. Existing public health centers throughout the State meet less than one-half of the existing need. Material more accurately depicting this problem is now being collected and analyzed.

"It is difficult to state whether the provision of hospital beds, diagnostic facilities, health centers, or public health departments should be the most emphasized. There is such a close relationship to all of the factors concerned in the improvement of public health that all of these factors will have to be considered and probably increased concurrently."

In order to assist your secretary in bringing together in one file the information which we have sent, I shall mention that this is supplementary to Governor Warren's letter of February 15 and my letter of February 2.

If there is any further information which you would like to have concerning California, please let us know.

Sincerely,

Helen R. MacGregor,
Private Secretary.

The State of Colorado,
Executive Chambers,
Denver, March 12, 1949.

Hon. H. Alexander Smith,
United States Senator from New Jersey,
Senate Office Building, Washington, D. C.

Dear Senator Smith: Receipt is acknowledged of your recent letter relating to national health legislation now pending before Congress.

I have asked appropriate State officials and interested groups and individuals to advise me as to their opinion of the relative merits of the pending legislation.

It is the considered opinion of qualified public health people that a fundamental requirement of a sound health program must have its roots in the provision of basic health services to all persons in all areas of the State. This can be accomplished when our local health departments are uniformly established and operating. When these basic needs are provided for locally, sound judgments may then be made as to the manner in which they should be supplemented.

From information which has come to my attention, it would appear that no clearly defined preference has been expressed by the people of Colorado for either of the proposed bills. Society,[1] as you no doubt know, has gone on record as approving and supporting the principles of Federal grant program, although I understand that this support has been given with reservations particularly related to the administration of the plan. A number of other groups in the State, including some farm organizations, are supporting compulsory health insurance.

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[1] Editorial note.—Reference is presumably to the Colorado Medical Society.

I am informed that at the present time between twelve and thirteen hundred of the State's doctors are participating in Colorado Medical Service, Inc., which is a complete surgical service available to subscribers with benefits predicated on a sliding-scale income basis. Subscribers at the present time number somewhat in excess of 200,000, of which slightly more than 30,000 are in rural areas. Promotion of the plan, I understand, is being concentrated in rural sections of the State. At the same time a number of studies are now being conducted, the purpose of which is to discover gaps in the State's health services. I might also point out that the Blue Cross plan is widely supported in the State, and while I have no specific figures, I would say that the number of subscribers is in excess of those covered by the surgical plan.

I trust that this information will be of some assistance to your committee in formulating its decisions and in conducting its hearings.

Sincerely yours,

LEE KNOUS, *Governor.*

STATE OF DELAWARE,
EXECUTIVE DEPARTMENT,
Dover, March 15, 1949.

Hon. H. ALEXANDER SMITH,
Senate Building, Washington, D. C.

DEAR SENATOR SMITH: Thank you very kindly for your letter of February 26. I regret my slowness in answering your letter written during January, but due to the pressure because of the activities of the general assembly now in session, I have been unable to answer my mail promptly.

On the issue of the national health legislation which is now before Congress, I favor a State program aided by Federal grants.

Thank you for your interest in my standing on this matter.

Cordially,

ELBERT N. CARVEL, *Governor.*

STATE OF IDAHO,
OFFICE OF THE GOVERNOR,
Boise, February 7, 1949.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: By way of belated reply to your letter of January 24, may I say first that I have not changed my position on the matter of the solution of the national health problem.

I am firmly convinced that wide discretionary powers ought to reside in the States. Conditions vary widely in our several States and it is my feeling that this is not solely a Federal matter.

Very sincerely,

C. A. ROBINS, *Governor.*

STATE OF INDIANA,
Indianapolis 4, January 29, 1949.

Hon. H. ALEXANDER SMITH,
Senate Office Building, Washington, D .C.

MY DEAR SENATOR SMITH: In response to your letter of January 24, I am pleased to advise that I entertain but little sympathy for any vast expenditure of Federal money at this time in support of a Nation-wide health insurance plan, but of the two solutions suggested in your letter I would be inclined to favor a program of Federal grants-in-aid to the States.

We are making satisfactory progress in Indiana in this field at the present time and I do not believe that we should impose an added burden of taxes on our people until we see some relief from the present load.

Sincerely yours,

HENRY F. SCHRICKER, *Governor.*

State of Kansas,
Office of the Governor,
Topeka, March 22, 1949.

Hon. H. Alexander Smith,
The United States Senate, Committee on Labor and Public Welfare,
Washington, D. C.

Dear Senator Smith: This will acknowledge receipt of your communication of February 26 in which you request my opinion as to the respective merits of medical-care legislation pending in congressional committees. I assure you that I appreciate this opportunity to express my opinion on this important subject.

I feel very strongly that legislative matters dealing with changes in our present ideas and concepts of medical care, which would have such an important bearing on the future health of all the people, should be very carefully studied. I am certain that your committee is giving much thought and analysis to these problems.

The problems and needs in the field of medical care differ a great deal in the various States, and I question the advisability of a national program which would blanket in all the States through a general pattern. If States were permitted to work out their own problems in cooperation with the Federal Government in the field of medical care, patterns would be developed to meet the specific needs and wishes of the people of the States. Problems in the field of medical care are local problems and, in many instances, are being very satisfactorily handled by local community leaders. This initiative and desire on the part of the people to understand and to help solve their own problems has been one of the factors that made this country a strong Nation. It is my belief that whatever type of Federal legislation is proposed should be built around this principle of giving the people an opportunity of solving their own problems, with Federal help when needed.

I am certain that your committee has been presented with many conflicting views as to needs and desirability of national compulsory health insurance. In my opinion, whatever program is developed should result in the lowering of the total number of deaths, sickness, and suffering of our people. Shifting the cost of medical care from the individual to the State, or the Federal Government, will not of itself accomplish these worth-while objectives. If our objectives are to reduce suffering, sickness, and premature deaths of our people, then I believe it will be necessary for us to—

1. Provide more and better trained physicians, available to all the people, both in urban and rural communities.
2. The continuation of the Federal Hospital Construction Act, which is assisting communities to provide hospital facilities in which they may receive adequate medical care and diagnosis.
3. The continuation of assistance and expansion of full-time health units, so that all our people may receive the benefits of preventive medicine.
4. In certain groups of our population, funds are needed to bridge the gap so that hospital facilities and medical services are available to everyone. It appears to me that such voluntary programs as the Blue Cross and Blue Shield are being explored as a voluntary means to provide a uniform coverage of such costs. It may be that in lower economic groups, grants to the States to provide such services might be desirable.
5. A great deal of research is needed to provide the answers for the leading causes of death, such as heart disease, cancer, the vascular diseases, and others, and to control such illness as infantile paralysis, mental diseases, and many of the others about which we know very little at the present time.

I know that you, as a committee member, have a difficult task in trying to weigh the evidence that is brought before the committee. I hope the views I have expressed from Kansas may be of some assistance.

Sincerely yours,

Frank Carlson, *Governor.*

COMMONWEALTH OF KENTUCKY,
EXECUTIVE CHAMBER,
Frankfort, March 3, 1949.

Senator H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

DEAR SENATOR: As a former Member of Congress I realize how important it is to read legislation and when bills are submitted on the two broad alternatives now being considered as ways of improving the distribution of medical care in the United States, as outlined in your February communication, I shall be glad to receive them.

It was only after reading prepared bills that I ever committed myself as a Member of the House. To go into the merits of one and the demerits of the other would be somewhat superfluous in view of the lack of basic information on which my observations would have to be founded.

I have always been opposed to socialized or state medicine; however, I would not want to so classify a measure without ample opportunity to digest it thoroughly.

As described by you, national compulsory health insurance might well be, from the viewpoint of many people, wholly noncompulsory, thoroughly democratic, and constitute the only feasible means to effect a national health-insurance program. Whereas, on the other hand, a State program aided by Federal grants, from many people's viewpoint, might provide the only means of insuring widespread health benefits and still retain our basic institutions. Again, this program to some might only mean that the whole thing was designed for impotency and ineffectiveness, inasmuch as the States were being called upon to produce the complex organization and a considerable degree of the financial support, both of which, by past performance in similar or allied social undertakings, have shown a marked degree of incompetence and lack of sound financial support.

With best wishes and kind personal regards, I am

Sincerely yours,

EARLE C. CLEMENTS, *Governor.*

STATE OF LOUISIANA,
EXECUTIVE DEPARTMENT,
Baton Rouge, Feburary 22, 1949.

Hon. H. ALEXANDER SMITH,
United States Senator, Washington, D. C.

DEAR SENATOR SMITH: I am in receipt of your letter of January 24.

Perhaps an analysis of the medical and hospital services rendered by the State of Louisiana to its citizens would be of some value to your Committee on Labor and Public Welfare in considering the various health bills introduced in the Congress. Possibly no other State has assumed an equal responsibility for the health of its citizens.

For over 100 years the State of Louisiana has provided charity hospital and medical services for the acutely ill. Today, Louisiana maintains 3,981 beds in seven State charity hospitals located strategically throughtout the State to provide hospital and medical services to its indigent population. Based on 4.5 beds per 1,000 population, these charity beds are adequate to give hospital care to approximately 40 percent of the entire population.

During the fiscal year ending June 30, 1949, it is estimated that 100,000 admissions will be made to State hospitals. In addition to the regular admissions of the acutely ill, it is anticipated that approximately 700,000 visits will be made to the out-patient clinics. The vast majority of the cases are admitted to these charity hospitals on the certifications of the family physicians that these persons are medically indigent and are unable to pay for the entire costs of their medical care. When a person considered medically indigent is admitted to a State hospital, all costs of hospital and medical treatment are paid through State funds.

In addition to the care and treatment of the acutely ill, the State of Louisiana provides for 90 percent of the institutional care for the mentally ill and tubercular patients.

The State acute, tuberculosis, mental, and chronic disease hospitals carry a daily load of approximately 12,000 patients. In similar private and non-State hospitals in Louisiana, exclusive of Federal hospitals, the average daily load of all types of patients does not exceed 5,000. Below is a table showing the comparative institutional services provided by private and State-owned hospitals:

Estimated services provided by State-owned and private hospitals

Type of ownership	Private hospitals		State-owned hospitals	
	Number beds	Estimated annual patient-days	Number beds	Estimated annual patient-days
General	4,739	1,160,276	3,981	904,466
Mental	317	86,097	7,788	2,798,530
Tuberculosis	128	44,997	1,070	355,637
Chronic and other	308	79,628	292	14,288
Total	5,492	1,572,177	13,131	4,072,921

While institutional care is only a part of the entire program of providing adequate medical care, it is my feeling that your committee should give serious consideration to the responsibilities already assumed by the States. It should be pointed out that there are almost as many different types of medical care programs in the Nation as there are States. For this reason, I respectfully suggest that a national health program be somewhat flexible to avoid any serious repercussions on existing medical-care programs.

The States have made serious attempts to cope with their individual problems. They have acquired experiences and constructed facilities which will lend themselves to expanded medical care. Every advantage should be taken of these present accomplishments.

It is my feeling that we cannot leave to the States the care of the mentally ill and tuberculars and pass on to the Federal level the responsibility for care of the acutely ill. All types of illness, whether they be acute, chronic, or illnesses of mind, are problems of health which should be coped with through a unified program. It is not clear to me as to the the actual scope of the medical, dental, and hospital care provided in the bills before your committee.

If Federal funds are to be used for a more extensive program of medical care, consideration should be given to the possibility of using these funds through grants-in-aid programs. A State could use the assistance of the Federal funds to strengthen the areas of medical care where it is most defficient. In Louisiana we have gone far in providing for the acutely ill. Our needs for our mentally ill seem to be more pressing at this time. Possibly in some other State the reverse may be true. It seems that these problems could be approached on the State level much more effectively than could be expected from absolute direction by some Federal agency.

We are mailing to you, under separate cover, two publications issued by the State of Louisiana relative to our hospital and health problems. These publications were prepared prior to my administration. While I do not necessarily agree with all their contents, they set forth some of the problems relating to our health needs and they indicate the extent of hospital and medical care provided to those who are medically indigent.

Sincerely yours,

EARL K. LONG, *Governor.*

STATE OF MAINE,
OFFICE OF THE GOVERNOR,
Augusta, June 7, 1949.

Hon. H. ALEXANDER SMITH,
Senator From New Jersey,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: In answer to your request for an expression of opinion concerning the "kind of Federal legislation which ought to be enacted in order to achieve a better distribution of good medical services among the American people," I would say that there are no doubt many areas where better medical services are not only desirable, but imperative for so-called indigents. I doubt, however, if the most economical, or even the most effective solution can be found by compulsion under Federal law.

I believe that it is axiomatic that the more services provided by Government, then the more nearly we as a Nation are approaching a socialistic state. We have already taken many steps in this direction.

Specifically, your letter asked that I indicate any preference I might have between the administration proposal for compulsory health insurance and the alternative Taft method of grants-in-aid to States as an aid to working out programs of their own. Both methods, of course, are highly controversial. I believe the second method, that of grants-in-aid, would be preferable.

In either method, a very serious question would be that of controls in the Federal law, itself, or by regulations which would have the full effect and force of law.

The Taft measure, so-called, is imperfect. One of the greatest imperfections is a failure to spell out, in specific terms, those persons who would be eligible for assistance. However, the grants-in-aid principle is one which has been followed by the United States Public Health Service for many years in making funds available to States for health and assistance programs.

My preference for the Taft measure is based on several observations: First, present personnel and administrative procedures could be used, obviating any necessity for creating a new bureau, with hundreds of persons necessary to enforce a compulsory act as indicated in the administration proposal; second, the Taft measure would involve a minimum time to explore needs, and become effective; third, this grants-in-aid program would provide an adequate springboard for expansion, should this be deemed desirable; fourth, this plan would incorporate a measure of flexibility which would apparently be lacking in a compulsory pay-roll-deduction plan, in which there are bounds to be inequities; fifth, it would not necessitate scrapping the Blue Cross, the Blue Shield, and other plans which have been operating successfully over a period of years.

Certainly, we have in this country a growing group of medically indigent people, who under the current conditions do not receive adequate medical care. Whether this would be more equitably solved by the States themselves, or by Federal legislation is a moot question.

This is also a very real question as to whether or not the $3,000 income as an arbitrary dividing line between indigents and nonindigents, as set tentatively by the administration measure, is realistic.

Sincerely yours,

FREDERICK G. PAYNE.

EXECUTIVE DEPARTMENT,
Annapolis, Md., February 15, 1949.

HON. H. ALEXANDER SMITH,
Senate Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: The following statement is in reply to your recent letter requesting my views on legislation which would make available to all people medical and hospital services.

"Although the public health and medical professions of Maryland are greatly interested in the pending proposals of legislation designed to improve the Nation's health, it cannot be said that there is complete unity of opinion on any phase of the whole subject. Our public-health authorities have had unique experience in conducting a system of medical care for the indigent which was authorized at the 1945 session of the legislature and is now in its fourth year of operation. On the basis of that experience, they are firmly convinced that there is need for change in our present system of health and medical service and that in bringing this change about the Federal Government must have an important if not a paramount part.

The opinion of the practitioners of medicine appears to be sharply divided. A very considerable proportion, perhaps a majority, of them believes that changes in the existing system of medical practice are desirable and must come, but are fearful that in the absence of any considerable experience in organizing and administering service even remotely approaching in size that envisioned by some of the bills pending before Congress, there is great danger that a system will be adopted under which both the quality of medical care will suffer and its over-all cost greatly increase. A certain section of the medical profession opposes any change in the present situation, and this group by the intensity of its convictions exercises a far greater influence on the public attitude of the profession than its size would seem to justify.

In the face of these differences of opinion, the best that can be done at this moment is to state as accurately as is possible the views of those in charge of our existing service in the hope that their experience may be of some value.

Our health authorities are in general opposed to any national compulsory system of health insurance. Their own experience indicates clearly that no single administrative groups can conduct so enormous an organization without prohibitive overhead costs and that the service rendered by it inevitably tends to become perfunctory and routinized. They believe, therefore, that any compulsory insurance system must be based on small units under the complete control of nonprofit organizations governed by boards made up of both medical and lay members. The county is probably the largest practicable area for a single unit of service. The responsibility for choosing the administrative board and controlling its expenditures must be assumed by the local unit of government. If the efficiency of the service cannot be maintained by the local unit of government, it certainly cannot by maintained by a distant agency.

It must be recognized that the cost of good medical service by whomsoever rendered, will inevitably be high. Only the rich are now or will in the foreseeable future be able to assume unaided the cost of a serious or prolonged illness. The cost of catastrophic illness must therefore be met either by society as a whole or by spreading the risk over the whole people by some nonprofit scheme of insurance.

It is recognized by every physician that the most successful agency now rendering medical service is the voluntary hospital where the quality of medical care is maintained by the group of physicians responsible for choosing and supervising the staff of the institution. It seems probable, therefore, that by improving the status of our existing hospitals and providing new ones where needed we will bring into being the agency needed to supply complete medical service to any insured population. Premiums for unemployed persons and for those receiving public assistance must needs be paid from public funds.

It is unfortunate that a small group within the organized medical profession has during the past few decades so discouraged experiments in medical care differing in any essential way from the existing system that we have almost no reliable experience on which to base a new plan. Until this experience can be had, we must proceed by the slow and expensive method of trial and error.

With kindest regards,

Sincerely yours,

W. Preston Lane, Jr., *Governor.*

The Commonwealth of Massachusetts,
Executive Department,
State House, Boston, February 10, 1949.

Hon. H. Alexander Smith,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

Dear Sir: As Governor of the Commonwealth of Massachusetts, I appreciate your thoughtfulness in writing me relative to the ever-increasing consideration which we in government must give to the over-all health situation in the United States.

Attached please find a copy of my inaugural address in which I gave special stress to this subject. May I call your attention particularly to the section on page 5 entitled "Health Insurance and Medical Care," the section on the department of mental health on page 7, the section on the department of public health on page 9, the section on housing on page 12, and the section on State employees on page 27.

As a State official, I must naturally be concerned with any program which affects the people of Massachusetts, and I am vitally interested in any program which will affect their health. It is my belief that neither a Nation-wide health-insurance system, as noted under "1" in your letter, nor a 5-year program of Federal grants-in-aid to the States as noted under "2," would effectually meet the needs of Massachusetts. I am convinced that under the Constitution of the United States and the amendments thereto, the health of the people is the prime responsibility of State government. The role of the Federal Government, therefore, is one of grants-in-aid to assist the States with, of course, proper coordination between the several States for the care of migrants and others who may move from one State to another.

I am, however, firmly convinced that any program dealing with the Nation's health must make adequate provision for the extension of health services and the prevention of disease. More extensive facilities are needed here in this State and perhaps even more so in other States, and while here in Massachusetts the distribution of professional personnel is not as inadequate as in others, we do have trouble in placing physicians, nurses, and specialists in some of our rural areas. I believe it is possible to extend more adequate health services to the people if, on the pattern of existing techniques, we make available to more people services that are already available to some.

However, in order to reply intelligently to your letter, I am asking my staff to study carefully the problem for Massachusetts; and while it will not be possible for us to present you with a detailed pattern for the Commonwealth, we do intend to give you a more complete reply to your letter as to how we feel the problem might be met in this State.

Sincerely yours,

PAUL A. DEVER.

THE COMMONWEALTH OF MASSACHUSETTS,
EXECUTIVE DEPARTMENT,
State House, Boston, February 2, 1949.

Hon. H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

MY DEAR SENATOR SMITH: This is to acknowledge receipt of yours of January 24, 1949.

On January 6, 1949, when I took office, I delivered an inaugural address to both branches of the legislature which contained, among other things, the following reference to health insurance and medical care.

"Repeated and protracted illness, especially that which strikes down the family breadwinner, is the source, directly or indirectly, of two-thirds of our cases of poverty. There is far more unemployment traceable to illness than to economic causes, except perhaps at the depths of great business and industrial depressions. The lack of prompt and adequate medical and hospital care during the first period of illness or nonindustrial injury drags out the initial incapacity and consequent absence from employment. Worse yet, it gives rise to later conditions which are far more impoverishing than the original source of disability. The welfare of the state is directly affected, since the body politic can be no more sound than the health of its citizens. Industrial production is restricted and industrial efficiency is impaired. For that reason, 30 percent of our industries already provide some kind of health insurance for their workers. Some authorities estimate this percentage at a much higher figure. The costs and ravages of illness are the hazards least often provided against in family budgets. Accordingly, a system of compulsory health insurance for our industrial workers and their families should be established. In the case of the worker himself, it should embrace disability compensation benefits equal to existing employment security payments. It should provide the means of procuring, in behalf of the worker's entire family, adequate medical and hospital care by physicians and institutions of his own choice. This is not socialized medicine. The cost of this protection should be met by joint contributions of both management and the employees themselves. Three States, Rhode Island, California, and New Jersey, have already enacted laws making provision against the hardships of unemployment due to sickness and nonindustrial injury. There are wide differences among these three laws although they are all designed to meet the same needs. I recommend that the great and general court investigate and study all three, together with any other pertinent material which may be brought to your attention, to the end that in this session of the legislature we may create a sound, workable system to provide our people with cash sickness benefits and insure their receiving adequate medical care."

The foregoing sets forth fully my views on the subject matter of your letter. I confidently expect that our legislature will report some kind of legislation to carry out the recommendations I made to it. Obviously, the legislators have a wide choice in the matter, but I expect it will be more in keeping with the second of the two plans which you say is now pending before the United States Senate than with the first one.

Sincerely yours,

PAUL A. DEVER,
Governor of the Commonwealth.

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
Lansing, February 25, 1949.

Hon. H. ALEXANDER SMITH,
Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: Thank you for your letter of January 24, relative to my preference in developing some kind of health program for the people of this country.

First let me say that I was delighted to see you at the inaugural, and second that I notice that as a good Republican, you are clinging to Eightieth Congress letterhead.

It seems to me that the President's proposal for health insurance reasonably meets the problem of health care and maintains the integrity of the medical profession. These I would judge to be the objectives most important to obtain. Just how successful your suggested grant-and-aid program would be, I am not so sure.

This matter is one of vital concern to all of the people of this country, and I hope that your committee will give the matter full and sympathetic consideration.

Sincerely yours,

G. MENNEN WILLIAMS, *Governor.*

[Telegram]

ST. PAUL, MINN., *March 17, 1949.*

Senator H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.:

In reply to your recent letters concerning proposed Federal health legislation, I wish to assure you that I am in full agreement with you as to the problem we face. That of making good medical and hospital services available to all the people regardless of their individual ability to pay. Some plan must be developed without delay so that lower-income families will not be crushed by the burden of doctor and hospital bills. The point I want to emphasize is that any legislation enacted by Congress will best meet the need if the States are given wide latitude in the administration of the program with a minimum of Federal regulations. Although I am not inclined to favor the compulsory plan as I now understand it, I do feel that some middle course can be followed to meet the health needs of our people.

LUTHER W. YOUNGDAHL,
Governor of Minnesota.

STATE OF MISSOURI,
EXECUTIVE OFFICE,
Jefferson City, February 22, 1949.

Hon. H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: In reference to your letter of January 24, will state that the Division of Public Health and Welfare of the State of Missouri has made the following suggestions to me:

"The officials in our Division of Health have reported to me that in their estimation they would prefer to see plan No. 1 adopted for the following reasons:

"1. This would provide a uniform plan for health services in all of the States, whereas, under plan No. 2, we would have as many different plans as we have States.

"An example in point was the EMIC plan, emergency maternal and infant care, which functioned during the past World War. Here each State had its own yardstick for measuring benefits, and a young mother might be entitled to $75 if she lived in one State, but only $30 if she lived in a different State. State health officials were continually plagued by the disparity in the grants from one State to another.

"On health and medical services there does not appear to be enough difference in the needs from State to State to warrant different plans of administration among the States.

"2. Another reason why we favor plan No. 1 is that, where the individual's wages are deducted, as here, the wage earner feels that he is paying for the service he gets, and it is not regarded as a dole. This would tend to preserve the individual's sense of responsibility as a citizen, which we believe is an important consideration in any program of this nature."

Yours truly,

FORREST SMITH.

STATE OF NEBRASKA,
EXECUTIVE OFFICE,
Lincoln, March 8, 1949.

Hon. H. ALEXANDER SMITH,
United States Senator, Washington, D. C.

DEAR SENATOR SMITH: Thank you for your letter of February 26 concerning the issue of national health legislation which is now before the Congress of the United States.

The medical profession of Nebraska, together with a large part of the population, is against any legislation which would impose upon our citizens compulsory health insurance or any system of medical care that would be under national control. For your information, we are enclosing a resolution which was recently passed by the unicameral legislature.

We have in Nebraska a prepaid medical-care plan which seems to be very well received. If more detailed information is required, I suggest that you contact Dr. W. S. Petty, director of health for the State of Nebraska. His office is located in the Capitol Building, Lincoln, Nebr.

Sincerely,

VAL PETERSON.

LEGISLATIVE JOURNAL

Sixty-first session—fourth day

LEGISLATIVE CHAMBER,
Lincoln, Nebr., January 7, 1949.

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LEGISLATIVE RESOLUTION 2, RE MEMORIALIZING THE CONGRESS OF THE UNITED STATES WITH RESPECT TO A NATIONAL COMPULSORY SICKNESS INSURANCE PROGRAM

Introduced by Arthur Carmody, of Hitchcock; Earl J. Lee, of Dodge; and Lester H. Anderson, of Hamilton.

"Whereas the American people now enjoy the highest level of health, the best standards of scientific medical care, and the finest medical institutions ever attained by any major country in the world; and

"Whereas these accomplishments of American medicine are the results of a free people working under a system of free enterprise; and

"Whereas the experience of all countries where government has assumed control of medical care has been a progressive deterioration of medical standards and medical care, to the detriment of the health of the people: Now, therefore, be it

"*Resolved by the members of the Nebraska Legislature in sixty-first session assembled:*

"1. That the Legislature of the State of Nebraska respectfully requests the Congress of the United States to refrain from imposing upon the citizens of this Nation any form of compulsory insurance or any system of medical care designed for national bureaucratic control.

"2. That Nebraska Senators and Representatives now in the Congress of the United States be and are hereby respectfully requested to use every effort at their command to prevent the enactment of such legislation.

"3. That copies of this resolution be transmitted by the Clerk of the Legislature to the President of the United States, the Presiding Officer of the United States Senate, the United States House of Representatives, and to each Senator and Congressman from Nebraska."

STATE OF NEW HAMPSHIRE,
EXECUTIVE DEPARTMENT,
Concord, January 26, 1949.

Hon. H. ALEXANDER SMITH,
Committee on Labor and Public Welfare,
United States Senate, Washington, D. C.

MY DEAR SENATOR: I have been giving your letter of January 13 considerable thought.

The medical profession in New Hampshire, as far as I know, is unanimously against any form of Federal control of the practice of medicine, and I believe that the people of the State are, in a great majority, of the same opinion.

It is apparent that the experience of England with socialized medicine has never been a happy one, from the point of view of the patient or the physician, and there seems to be considerable sentiment here that the plan would be a rather costly one. I believe that the New Hampshire delegation in Washington have already gone on record as against socialized medicine.

As to the preference between the general alternatives outlined in your letter, I do not believe there is much if any preference, certainly as far as the people of New Hampshire are concerned.

I appreciate your letter asking for my comments and shall be glad to hear from you again as proposed legislation develops.

Sincerely yours,

SHERMAN ADAMS.

STATE OF NEW MEXICO,
OFFICE OF THE GOVERNOR,
Santa Fe, March 21, 1949.

Hon. H. ALEXANDER SMITH.
United States Senator, Washington 25, D. C.

DEAR SENATOR SMITH: Reference is made to your letter of February 28, in which you ask again regarding New Mexico's attitude on national health legislation.

Since the legislature has been in session, I have not had a great deal of time to go into such matters, which accounts for my delay in answering your letter.

I still feel now as I did when I wrote you in December 1947, that I should be largely guided by the thinking of our congressional delegation. Our own public health department, as I informed you, is still not convinced that either measure will fit New Mexico's particular needs.

With best wishes and kindest regards, I am,

Yours sincerely,

THOMAS J. MABRY, *Governor.*

STATE OF NEW YORK,
EXECUTIVE CHAMBER,
Albany, January 19, 1949.

Hon. H. ALEXANDER SMITH.
United States Senate, Washington, D. C.

DEAR ALEX: I haven't the slightest doubt about the correct answer to your letter of January 13. Whatever is done should be done through the States. Anything else will wreck the standards of medical care in this country and bring us to the same ruinous condition of Germany and Russia, where medical care was nationalized down to a level where few got any and what they got was no good.

With all good wishes and the best of good wishes for your success in winning a majority of the Senate to the viewpoint I know we both share,

Sincerely yours,

THOMAS E. DEWEY.

P. S.—I hope to be in Washington on the afternoon of February 8 and part of the 9th and perhaps we could get together then for a visit, but if it does not work out I am in New York almost every week and will be delighted to see you at any time.

T. E. D.

State of North Carolina,
Governor's Office,
Raleigh, February 3, 1949.

Hon. H. Alexander Smith,
Senator from New Jersey,
Senate Office Building, Washington, D. C.

Dear Senator Smith: Governor Scott has asked me to acknowledge your letter of January 14 with reference to the national health program.

The Governor naturally is quite interested in supporting an intelligent program designed to make good medical and hospital services available for all the people regardless of their inability to pay. At the present time, however, Governor Scott is busy with a large-scale program pending in the current North Carolina General Assembly and has been unable to give his attention to the various methods for carrying out this Nation-wide program which you discuss in your letter.

He has requested that I forward your communication to Dr. J. W. Norton, State health officer, for his information, with the request that he pass on to you any observations he has made of the programs discussed.

Sincerely,

William D. Snider, *Special Assistant.*

North Carolina State Board of Health,
Raleigh, February 18, 1949.

Senator H. Alexander Smith
Senate Office Building, Washington, D. C.

Dear Senator Smith: Your letter addressed to Governor Scott along with a copy of letter written to you by Mr. William D. Snider, special assistant to Governor Scott, has been forwarded to this office.

In the first place, I would like to express agreement with your opinion shown in the last paragraph of your letter. Also I would like to express a preference for solution No. 2 expressed in bills now up for consideration.

We are happy to report that great progress has already been made in North Carolina toward making good hospital and medical care and preventive medicine services available to all the people regardless of their ability to pay. This State has done some pioneering work in the development of the Blue Cross plan and our very progressive State medical society is about ready to present a Blue Shield or medical-care plan after about 2 years' intensive work by a very competent committee. We realize that much pressure for immediate Federal action is coming from States where less medical leadership in the development of necessary plans and actions prevail.

I wish to emphasize that I am speaking personally and that I cannot speak for our Governor even though I am familiar with his speeches in which he has recommended a very thorough and comprehensive plan for removal of service deficits. We have a very comprehensive program recommended by the Governor, and now being considered by our general assembly, for improvements in roads particularly in the rural areas; rural electrification improvements; rural telephone service; hospital construction; the training of physicians, dentists, and assisting personnel; and improvements in public schools. In our public-health program emphasis is being given to the development and strengthening of county, city-county, district, and State health departments and the training of necessary professional and assisting personnel.

Very sincerely,

J. W. R. Norton, M. D.,
Secretary and State Health Officer.

State of Oregon
Executive Department,
Salem, March 8, 1949.

Hon. H. Alexander Smith,
United States Senate, Washington, D. C.

Dear Senator Smith: I am sorry not to have given you an earlier answer to your letter, but due to the pressure of legislative matters during our biennial session now under way, I have been extremely busy.

I am opposed to socialized medicine as such and I would want to scrutinize any proposed legislation very carefully before I passed an opinion on it. I also agree with you that it is a matter in which the States should have some voice.

Thank you for bringing the proposals to my attention.

Very truly yours,

DOUGLAS MCKAY, *Governor.*

COMMONWEALTH OF PENNSYLVANIA,
GOVERNOR'S OFFICE,
Harrisburg, January 28, 1949.

HON. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: Your letter of January 14 has been received. There has not been any change in our attitude, as indicated in my letter to you of October 17, 1947, and wish to assure your committee when it assumes the responsibility of considering legislation having to do with the over-all health situation in the United States that we conform strictly to our previous stand.

A recent survey of the public health facilities in this Commonwealth shows the Pennsylvania population to be receiving adequate medical care. There has been and still is much dispute on this question, but with very few exceptions practically all, even our rural areas, are covered with relatively accessible hospital and health srevices.

With respect to the handling of public health problems by our State Department of Health, the services are not unequally distributed throughout the Commonwealth. The department has one or more clinics for tuberculosis, venereal disease, and maternal and child health in every county, has periodic clinics throughout the State for crippled children, maintains three tuberculosis sanatoriums and a hospital for crippled children, maintains programs covering rheumatic heart, cancer control, industrial hygiene, milk sanitation, stream pollution, restaurant hygiene, and many other sanitation functions which are operating in a most satisfactory manner, although still moderately curtailed by lack of trained professional and other personnel. Additional activities are being looked forward to on air pollution control, cleft palate, and an intensified school-health program.

In considering all of these activities, when brought into the various levels and the administrative services are completed, we can be very well pleased with the medical care of the Pennsylvania citizens.

Sincerely yours,

JAMES H. DUFF.

STATE OF SOUTH CAROLINA,
OFFICE OF THE GOVERNOR,
Columbia, January 27, 1949.

HON. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

MY DEAR SENATOR SMITH: In reply to your letter of January 14, 1948, asking for my views on pending national health legislation, permit me to refer you to my letter of December 19, 1947, on the same subject. I have not changed my views as expressed in this letter, a copy of which is enclosed.

I am in favor of the principle of governmental cooperation between the Federal Government and the State governments toward a solution of the Nation's vast health problems, but the field is one in which the primary responsibility is that of the States. Federal Government should assist the States in discharging this responsibility, and not undertake to take over any of their functions, or control their discretion in dealing with the problems of their citizens. Equality of medical care can be accomplished by cooperation, which aids in overcoming economic handicaps, and does not depend upon Federal assumption of control not given to it in the Constitution.

I hope your committee will call upon me if there is any further information I can give.

With kindest regards and best wishes.

Very truly,

J. STROM THURMOND, *Governor.*

DECEMBER 19, 1947.

Hon. H. ALEXANDER SMITH,
United States Senate, Chairman, Subcommittee on Health,
Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: In reply to your letter of November 8, I wish to state that I have delayed replying to your request in order that I might have a thorough study made of both bills by several parties. My first comment is that I feel that both bills are entirely too voluminous for the average citizen of the United States to interpret correctly without undue effort. I believe that there is a wealth of opportunity for a Member of Congress to scuttle both bills and write a simplified version incorporating the desirable parts of both.

Regarding the percentage of the population of South Carolina not getting adequate medical care today, our State Department of Health estimates that as a general rule one-third of the people are not getting adequate medical care and that an additional one-third are not getting the proper type, or complete, care. By this, I do not mean to imply in any way that many persons in South Carolina who need medical attention do not get it. However, I do not believe that more than one-third of our families are in financial position to pay for prolonged illnesses.

I cannot answer the question as to whether South Carolina would be in sympathy with a compulsory tax plan for Government-supervised medical services. If the Federal Government imposes such a tax as in S. 1320 naturally South Carolina must pay its part. If S. 545 is enacted, no one but the general assembly can say whether or not the State will appropriate matching funds. In general, South Carolina would be inclined to retain as much control as possible over the operations of a health plan in this State.

In each of our counties we have a county health department which handles health problems. However, 15 of our counties are entirely without hospitals and many more have inadequate facilities. We are also greatly in need of nurses, general practitioners, and specialists.

The new Federal-aid-to-hospitals program has just begun and it is too early to make any significant report. We are more than happy to have it and expect that it will have far reaching effects on the health of South Carolina.

I am very much in favor of better health facilities for our people. Enclosed herewith is a copy of my inaugural address in which I have devoted section 14 to health. This section begins on page 23 and outlines my feeling generally on this very important subject.

If there is any further assistance that I can be to your committee please do not hesitate to call on me.

If you are ever in the vicinity of Columbia I would be delighted to have you as a guest at the mansion.

With kindest regards and best wishes,

Very truly,

J. STROM THURMOND, *Governor.*

STATE OF SOUTH DAKOTA,
Pierre, January 22, 1949.

Hon. H. ALEXANDER SMITH,
United States Senator,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: This will acknowledge receipt of your letter of January 14th concerning our national health problems.

While, of course, it is almost impossible for me to state which of the two plans suggested by you would meet with the approval of our people and our state legislature, or whether either of them would, I personally favor the plan of Federal grants-in-aid to the States permitting the States themselves to decide whether or not they wish to avail themselves of such Federal grants and enabling them to develop their own program which would best meet their own needs.

Thank you for furnishing me this opportunity of an expression on this important subject.

Sincerely yours,

GEORGE T. MICKELSON, *Governor.*

STATE OF UTAH,
OFFICE OF THE GOVERNOR,
Salt Lake City, January 20, 1949.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR: This will acknowledge receipt of your letter dated January 14, 1949, relative to the over-all health situation in the United States emphasizing the need of medical and hospital services available to all the people, regardless of their individual ability to pay.

I have read your letter with much interest. However, I am wondering when and where Government aid is going to end. All of these things are worth while—and I agree with you that the need is there—but I fear we may go too far and find ourselves a socialized country. My only suggestion is that we had better stop and view the other side of this picture.

Sincerely yours,

J. BRACKEN LEE, *Governor.*

STATE OF VERMONT,
EXECUTIVE DEPARTMENT,
Montpelier, February 3, 1949.

Hon. H. ALEXANDER SMITH,
United States Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: This is to acknowledge your letter of January 14, to which I have been giving considerable thought.

It is probably necessary before any health program be estabilshed that there should be a broad and rather thorough survey of the health needs and resources of each State. This could be done as a Federal program or possibly on a grant-in-aid basis. If the Federal Government should lay down a yardstick of general requirements, then the States could carry out the survey. It would take several months, probably a year, to complete such a survey. After that, each State could develop a State plan which would state further its full needs and the manner in which these needs should be met. We feel in Vermont that health is a matter of vital importance, and I would suggest that there be continued on an increased scale the present health grant-in-aid programs that are working quite well.

This should be carried on while the factual data for the establishment of a plan are determined. We also feel that there should be grant-in-aid programs for increasing the number and size of our present medical schools for subsidizing the training of doctors, nurses, and technicians and for medical research. This could be done while the over-all health program is being developed.

I do not know what to say about a Nationwide health-insurance system. Whatever may be developed, however, I feel strongly should be administered by State agencies working under minimum Federal rules and regulations. Perhaps some program developed along the lines of Public Law No. 725 (Hill-Burton Act) would be a favorable approach to this problem.

Some consideration must be given, however, the provision for those people who have no income of any form and who are indigent mentally and physically and are wards for one reason or another of municipalities or States.

Most sincerely,

ERNEST W. GIBSON, *Governor.*

COMMONWEALTH OF VIRGINIA,
GOVERNOR'S OFFICE,
Richmond, January 19, 1949.

Hon. H. ALEXANDER SMITH,
United States Senate, Washington, D. C.

DEAR SENATOR SMITH: I have read with great interest your letter of January 14 in regard to the various proposals for financing medical and hospital services.

I am in fundamental disagreement with those who advocate Government operation of this type of program. One of the greatest threats to the continued virility of our democracy today is the burdensome public debt. All citizens who have had any experience with private debt recognize the necessity of giving first consideration to retiring their past obligations before expanding their scale of living to include additional luxuries. I feel strongly that the Federal Government should follow the same principle and should apply a substantial part of its income to retirement of the public debt, should eliminate insofar as possible existing grants-in-aid programs, and should leave to the States their inherent responsibility for promoting the welfare of their citizens.

I have felt for a long time that the system of grants-in-aid to the States contains the elements capable of destroying the self-reliance of the States and their people and also contains the even more serious potentialities of undermining our democratic system of government.

The various proposals for socialized medicine impress me as just another evidence of the dangerous trend toward a socialistic system and diminished individual liberty.

Very sincerely yours,

WM. M. TUCK.

STATE OF WASHINGTON,
EXECUTIVE DEPARTMENT,
Olympia, March 23, 1949.

HON. H. ALEXANDER SMITH,
Committee on Labor and Public Welfare,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: Based solely upon experience in our own State, I do not believe a national program is either desirable or necessary.

We have rather expanded medical services for the people of the State in the following particulars:

1. Widespread coverage through medical bureaus.
2. Widespread coverage through Blue Cross.
3. Social-security benefits that entitle some 65,000 aged in our State, as well as the indigent, the blind, and dependent children, to free medical, hospital, dental care, and to free appliances, and burial expenses.
4. The bill enclosed (S. 164) further expedites this program. It was enacted at the 1949 session of our legislature.[1]

From this you can see that a rather extensive coverage is given to the people in most categories, and that where they are destitute and cannot afford it, the State is taking care of them.

Sincerely,

ARTHUR B. LANGLIE, *Governor.*

STATE OF WISCONSIN,
EXECUTIVE OFFICE,
Madison, January 26, 1949.

HON. H. ALEXANDER SMITH,
United States Senator, Washington, D. C.

DEAR SENATOR: This is in reply to your letter of January 14, which I have read with interest.

Frankly, I cannot view either of the alternative plans outlined in your letter with enthusiastic favor. As a general principle, I am opposed to the application of State aids in those instances where the States have proved themselves capable of coping with a problem. I am opposed to the greater centralization of governmental authority in Washington.

If the Federal Government will practice an economy which will enable it to withdraw entirely from definite fields of taxation, leaving them to the State and local units of government, the States themselves will be able to solve many of the problems which in reality do not lie within the province of the Federal Government. My suggestion is that you prevail upon your colleagues to help accomplish this objective to the end that those functions of government which can be discharged on the local level be so discharged, and that government be returned to the people where it belongs.

Thank you for the opportunity to express myself on this subject.

Sincerely yours,

OSCAR RENNEBOHM, *Governor.*

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[1] EDITORIAL NOTE.—The act referred to, passed March 9, 1949, is entitled "An Act Relating to Unemployment Compensation; Providing for Experience-Rating Credit; Providing for Relief From Unemployment Caused by Sickness, Accident, or Injury; Providing for Benefits, Contributions, Funds, and Receipt of Moneys: Amending Chapter 35, Laws of 1945; Repealing Sections 108, 109, and 136 to 179, Inclusive, Chapter 35, Laws of 1945, and Chapter 50, Laws of 1947; Making an Appropriation; and Providing Effective Dates."

STATE OF WYOMING,
EXECUTIVE DEPARTMENT,
Cheyenne, March 5, 1949.

Senator H. ALEXANDER SMITH,
Senate Office Building, Washington, D. C.

DEAR SENATOR SMITH: I have at hand your letter inquiring as to the attitude of Wyoming toward the bills for socialized medicine. I cannot give you any very definite answer because I do not know what the sentiment would be in this State. As to myself, I am not at all certain that I approve either of your proposals.

Sincerely yours,

A. G. CRANE, *Governor.*

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